SERFF Tracking Number:	*UHLC-125976134*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41226*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Arkansas Global Choice*		
Project Name/Number:	*/*		

Filing at a Glance

Company: United HealthCare Insurance Company

Product Name: Arkansas Global Choice	SERFF Tr Num: UHLC-125976134	State: ArkansasLH
TOI: H21 Health - Other	SERFF Status: Closed	State Tr Num: 41226
Sub-TOI: H21.000 Health - Other	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: Ebony Terry	Disposition Date: 01/12/2009
	Date Submitted: 01/06/2009	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Authorized
Project Number:	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Large
Overall Rate Impact:	Group Market Type: Employer
Filing Status Changed: 01/12/2009	
State Status Changed: 01/12/2009	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Arkansas Global Choice Filing (Please see attached Cover letter for filing description)

Company and Contact

Filing Contact Information

Ebony Terry, Compliance Analyst	Ebony_N_Terry@uhc.com
4 Taft Court	(301) 838-5611 [Phone]

SERFF Tracking Number:	*UHLC-125976134*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41226*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Arkansas Global Choice*		
Project Name/Number:	*/*		

Rockville, MD 20850 (301) 838-5676[FAX]

Filing Company Information

United HealthCare Insurance Company
450 Columbus Boulevard
PO Box 150450
Hartford, CT 06115-0450
(215) 653-8046 ext. [Phone]

CoCode: 79413
Group Code: 707
Group Name:
FEIN Number: 36-2739571

State of Domicile: Connecticut
Company Type: Life and Health
State ID Number:

SERFF Tracking Number:	*UHLC-125976134*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41226*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Arkansas Global Choice*		
Project Name/Number:	*/*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United HealthCare Insurance Company	$50.00	01/06/2009	24846073

SERFF Tracking Number:	*UHLC-125976134*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41226*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Arkansas Global Choice*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/12/2009	01/12/2009

SERFF Tracking Number:	*UHLC-125976134*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41226*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Arkansas Global Choice*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 01/12/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UHLC-125976134*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41226*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Arkansas Global Choice*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Cover Letter and Forms Listing	Approved-Closed	Yes
Form	Global Choice Rider	Approved-Closed	Yes
Form	Global Choice Amendment (Choice Plus)	Approved-Closed	Yes
Form	Global Choice Amendment (Non-Differential)	Approved-Closed	Yes

SERFF Tracking Number:	*UHLC-125976134*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41226*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Arkansas Global Choice*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: GLBCHC.07.AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	GLBCHC.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Global Choice Rider	Initial			X07I_RDR_INTL_GLOBALCHC_KA_CS_Rev2.pdf
Approved-Closed	SBN.GLBCHCCP.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Global Choice Amendment (Choice Plus)	Initial			X07I_SBN_CHCPLS_INTL_GLOBALCHC_KA_CS_Rev4.pdf
Approved-Closed	SBN.GLBCHCND.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Global Choice Amendment (Non-Differential)	Initial			X07I_SBN_NONDIFF_INTL_GLOBALCHC_KA_CS_Rev3.pdf

United HealthCare Insurance Company

NOTE: Product name of "Global Choice" filed as variable to allow name change in future.

[Global Choice] Rider

[1]Include when Global Choice Benefits are available for Expatriates.

[2]Include when Global Choice Benefits are available for Inpatriates.

[3]Include when Global Choice Benefits are available for both Expatriates and Inpatriates.

[4]Include when International Benefits are available to Enrolled Dependents.

[This Rider to the Policy provides Benefits for Covered Health Services that are provided outside the *United States* to Subscribers who are *[[1]Expatriates]* [[3]or] *[[2]Inpatriates]* [[4]and to their Enrolled Dependents].]

International Benefits

[1]Include when Global Choice Benefits are available for Expatriates.

[2]Include when Global Choice Benefits are available for Inpatriates.

[3]Include when Global Choice Benefits are available for both Expatriates and Inpatriates.

[4]Include when International Benefits are available to Enrolled Dependents.

[[[1]We will pay Benefits for Covered Health Services provided by or under the direction of a Physician to Subscribers who are *[[1]Expatriates]* [[3]or] *[[2]Inpatriates]* [[4]and to their Enrolled Dependents].]

Include when plan provides benefits for emergency evacuation. Benefits for Emergency Evacuation should not be included if the plan covers only Inpatriates.

[Emergency Evacuation]

[If you suffer a Sickness or Injury outside the *United States* and adequate medical facilities are not available locally in the opinion of our *Medical Director* or the *Medical Director* of our affiliate or authorized vendor under our direction, we will provide emergency evacuation (under medical supervision if necessary) to the nearest facility capable of providing adequate care by whatever means is necessary. Covered Health Services include arranging and providing for transportation and related medical services (including cost of medical escort) and medical supplies necessarily incurred in connection with the emergency evacuation.]

Include when plan provides benefits for medical repatriation. Benefits for Medical Repatriation should not be included if the Rider covers only Inpatriates.

[Medical Repatriation]

[After you receive initial treatment and stabilization for a Sickness or Injury outside the *United States*, if the attending Physician and our *Medical Director* or the *Medical Director* of our affiliate or authorized vendor under our direction determine that it is medically necessary, we will transport you back to your permanent place of residence for further medical treatment or to recover. Covered Health Services include arranging and providing for transportation and related medical services (including medical escort if necessary) and medical supplies necessarily incurred in connection with the repatriation.

[1]Include appropriate number; include "s" if more than one.

Benefits are limited to [[1]one - five] medical repatriation[[1]s] per Sickness or Injury, provided that all of the following apply:

- The treatment required is a Covered Health Service.

- The treatment is recommended by your Physician.
- For medical reasons, treatment is not available locally in the foreign country. We must confirm that treatment is not available locally in advance.

You must provide us with any information or proof that we may reasonably request.

Benefits for medical repatriation are only available if all arrangements for your repatriation are approved in advance and arranged by us. Physicians from our appointed representatives will discuss all relevant factors with your own Physician before authorizing payment for repatriation.

[1]Include when plan provides benefits for companion travel.

[2]Include when plan provides benefits for domestic partners.

[3]Include when companion travel benefits are limited and include the applicable dollar and day limit; include "s" if more than one day.

[[1]Benefits are also provided for the reasonable travel costs for your relative [[2]or your Domestic Partner] to accompany you if authorized in advance of the repatriation. [[3]Benefits are provided for an allowance of up to $[1 - 1,000] per day for up to [one - ten] [11 - 60] day[s] towards the living expenses incurred by the person accompanying you.]]

[1]Include when plan provides benefits for companion travel.

We will pay for you [[1]and the person accompanying you] to return to where you were repatriated from. We must approve in advance all arrangements for your return and you must make the return journey within 14 days of the end of the treatment you were repatriated for. We will pay either of the following, whichever is the lesser amount:

- The actual cost you incur for the journey.
- The cost of a scheduled return economy class journey by the most direct route available.]

Include when plan provides benefits for repatriation of remains.

[Repatriation of Remains]

[In the event of your death, we or our affiliate or authorized vendor will render assistance and provide for the return of mortal remains. Services include:

- Location of a sending funeral home.
- Transportation of the body from the site of death to the sending funeral home.
- Preparation of the remains for either burial or cremation.
- Transportation of the remains from the funeral home to the airport.
- Minimally necessary casket or air tray for transport.
- Coordination of consular services (in the case of death overseas).
- Procuring death certificates.
- Transport of the remains from the airport to the receiving funeral home.

Other services that may be performed in conjunction with those listed above include making travel arrangements for any traveling companions and identification and/or notification of next-of-kin.]

Include table below if benefits are provided for Emergency Evacuation, Medical Repatriation and/or Repatriation of Remains.

[Covered Health Service]	[Benefit *(The Amount We Pay, based on Eligible Expenses)]*	[Apply to the Out-of-Pocket Maximum?]	[Must You Meet Annual Deductible?]
Include when benefits are provided for Emergency Evacuation, Medical Repatriation and/or Repatriation of Remains. **[Emergency Evacuation] [,] [Medical Repatriation] [and] [Repatriation of Remains]**			
	[International] [[50 - 100]%] [100% after you pay a Copayment of $[25 - 300] per transport] [100% after you pay a Copayment of $[300 - 1,000] per day] [100% after you pay a Copayment of $[300 - 1,000] per day, up to a per day maximum of $[300 - 1,000]]	[Yes] [No]	[Yes] [No]

Include when outpatient prescription drugs are covered under this Rider.

[Outpatient Prescription Drugs]

[Outpatient prescription drugs that are prescribed for you by your Physician to treat a Sickness or Injury for which Benefits are provided as described in the *Certificate*. Benefits for outpatient prescription drug products are available when the outpatient prescription drug product meets the definition of a Covered Health Service. Benefits are not available for over the counter drugs or other drugs or treatments available without a prescription. Prescriptions must be paid for out-of-pocket by the Covered Person and submitted to us for reimbursement.]

[Covered Health Service]	[Benefit *(The Amount We Pay, based on Eligible Expenses)]*	[Apply to the Out-of-Pocket Maximum?]	[Must You Meet Annual Deductible?]
[Outpatient Prescription Drugs]	***[International]*** [[50 - 100]%] [100% after you pay a Copayment of $[1 - 200] per prescription order or refill]	[Yes] [No]	[Yes] [No]
[1]Include Network and Non-Network rows when outpatient drugs are	***[[1]Network] [[2]U.S.]***		

[Covered Health Service]	[Benefit *(The Amount We Pay, based on Eligible Expenses)]*	[Apply to the Out-of-Pocket Maximum?]	[Must You Meet Annual Deductible?]
covered under this Rider (rather than under an outpatient RX rider) and when this Rider is issued with Choice Plus product. [2]When this rider is issued with a Non-Differential PPO product and when outpatient drugs are covered under this Rider rather than under an outpatient RX rider, completely delete the Non-Network row and the "Network"heading and use the "U.S." Heading.	[[50 - 100]%] [100% after you pay a Copayment of $[1 - 200] per prescription order or refill]	[Yes] [No]	[Yes] [No]
	[[1]Non-Network] [[50 - 100]%] [100% after you pay a Copayment of $[1 - 200] per prescription order or refill]	[Yes] [No]	[Yes] [No]

Exclusions and Limitations

Include when outpatient prescription drugs are covered under this Rider. Delete when all outpatient prescription drugs are covered under a separate outpatient prescription drug rider.

[The exclusion for *Drugs* in the *Certificate* is replaced with the following:

Drugs

1. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
2. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.
3. Over-the-counter drugs and treatments.
4. Growth hormone therapy.]

This exclusion will apply when this rider provides only International Benefits for drugs and when Network/Non-Network Benefits (Choice Plus) or U.S. Benefits (Non-Differential PPO) are provided under the Outpatient Prescription Drug Rider.

[1]Include Network and Non-Network option when this Rider is issued with Choice Plus.

[2]Include U.S. option when this Rider is issued with Non-Differential PPO.

[5. [[1]Network and Non-Network] [[2]*U.S.*] Benefits for prescription drug products for outpatient use that are filled by a prescription order or refill. [[1]Network and Non-Network] [[2]*U.S.*] Benefits for outpatient prescription drug products are provided under the Outpatient Prescription Drug Rider.]

The exclusion for *Travel* in the *Certificate* is replaced with the following:

Travel

[1]Include when plan provides benefits for any service described above for emergency evacuation, medical repatriation and repatriation of remains. Include "and" and "comma" appropriately and select the services that are covered.

1. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion. [[1]This exclusion does not apply to [*Emergency Evacuation*] [,] [and] [*Medical Repatriation*] [and] [*Repatriation of Remains*] for which Benefits are described above.]

The exclusion for services otherwise covered under the Policy in the *Certificate* under *All Other Exclusions* is replaced with the following:

All Other Exclusions

2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:

[1]Include when Benefits are provided for immunizations for travel.

- Required solely for purposes of career, school, sports or camp, travel, employment, insurance, marriage or adoption. This exclusion does not apply to immunizations for [[1]travel,] career or employment.
- Related to judicial or administrative proceedings or orders.
- Conducted for purposes of medical research.
- Required to obtain or maintain a license of any type.

Include when claims payment restrictions apply.

[Claims]

[How Claims will be Paid]

[We make all payments, in our discretion, in one of the following ways:

- In the currency in which Premiums are being paid.
- In the currency of the invoices relating to the claim.
- In *U.S.* dollars.

We cannot pay in any other currency. Sometimes international banking regulations do not allow us to make a payment in the currency requested. If so, we will send a payment in the currency in which the Policy Premiums are paid. It is your responsibility to pay any charges which are not eligible for payment under the Policy.]

[How Exchange Rates will be Calculated]

[If it is necessary to make a conversion from one currency to another, we will use the mid-market exchange rate in effect on the date the invoice was generated.]

Defined Terms

[1]Include if only one definition is added.

[2]Include if both definitions of Expatriate and Inpatriate are added.

The following new [[1]definition is] [[2]definitions are] added:

Include when Global Choice benefits are available for Expatriates.

[1]Include if we or the group establish residency criteria for eligibility; include "s" if more than one day.

[Expatriate - an Eligible Person who is resident outside the *United States*. If you cease to be resident outside the *United States,* you must notify the Enrolling Group and us immediately. [[1]You are considered to be resident outside the *United States* if you intend to make that locality your home for a period of [one - ten] [11 - 365] day[s] or longer.]]

Include when Global Choice benefits are available for Inpatriates.

[Inpatriate - an Eligible Person who is a foreign national resident within the *United States*.]

Include "Dependent" when the group modifies the definition of "Dependent" to include the parents of the Subscriber or the Subscriber's spouse.

The definitions of [Dependent,] Eligible Person, Experimental or Investigational Services and Unproven Services in the *Certificate* are replaced with the following:

Include Dependent definition when the group modifies the definition of "Dependent" to include the parents of the Subscriber or the Subscriber's spouse.

[1]Include bracketed text if group purchases Domestic Partner coverage.

[Dependent - the Subscriber's legal spouse or an unmarried dependent child of the Subscriber or the Subscriber's spouse. [[1]All references to the spouse of a Subscriber shall include a Domestic Partner.] The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.

[1]Include if group chooses to include the parents of the Subscriber's spouse as Dependents.

The definition of Dependent also includes parents of the Subscriber [[1]or the Subscriber's spouse].

Include when U.S. residency is required.

[To be eligible for coverage under the Policy, a Dependent must reside within the United States.]

The definition of Dependent is subject to the following conditions and limitations:

[1]Modify age as appropriate to accommodate group decision.

- A Dependent includes any unmarried dependent child under [[1]18-19] years of age.

[2-3-4]Delete #2 if group does not use Full-time Student criteria and include #3 below for IRS criteria (cannot exceed age 24) or #4 if IRS criteria does not apply. Modify ages as appropriate to accommodate group decision.

- [[2]A Dependent includes an unmarried dependent child who is [[1]18 - 19] years of age or older, but less than [[1]23 - 30] years of age only if you furnish evidence upon our request, satisfactory to us, of all the following conditions:
  - The child must not be regularly employed on a full-time basis.
  - The child must be a Full-time Student.
  - The child must be primarily dependent upon the Subscriber for support and maintenance.]
- [[3]A Dependent includes an unmarried dependent child who is [[1]18 - 19] years of age or older, but less than [[1]23 - 24] years of age only if the child meets the Internal Revenue Service definition of a "qualifying child" or a "qualifying relative."]

- [[4]A Dependent includes an unmarried dependent child who is [[1]18 - 19] years of age or older, but less than [[1]23 - 30] years of age only if the following are true:
  - The child is not regularly employed on a full-time basis and
  - The child is primarily dependent upon the Subscriber for support and maintenance.]
- A Dependent includes an unmarried dependent child of any age who is or becomes disabled and dependent upon the Subscriber.

Include paragraph below when group intends to allow coverage for a dependent child until the last day of the year in which he/she reaches the limiting age. If different limits apply to Full-time Student, use language in that provision to address the full-time student criteria and the provision below to address the other dependent children.

[A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the year following the child's [[1]18 - 30th] birthday.]

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

Include when the group does not elect double coverage.

[A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.]]

[1]Include when Global Choice Benefits are available for Expatriates.

[2]Include when Global Choice Benefits are available for Inpatriates.

[3]Include when Global Choice Benefits are available for both Expatriates and Inpatriates.

Eligible Person - an employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Policy. An Eligible Person must be an [[1]*Expatriate*] [[3]or] [[2]*Inpatriate*].

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration* (FDA) to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- When medical, surgical, diagnostic, psychiatric, substance abuse and other health care services, technologies, supplies, treatments, procedures, drug therapies, medications and devices are provided outside the *United States*, the determination of status as an Experimental or Investigational Service will be made in our reasonable judgment based on clinical standards that apply within the country in which the service is provided and relevant regulatory review processes and requirements.

Include when the group purchases benefits for clinical trials.

- [Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.]

- Life-Threatening Sickness or Condition. If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.

  For services provided outside the *United States*, if the service is one that requires review and approval by a governmental agency, then the service must be approved by that agency.

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)

- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at [www.myuhc.com].

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.

- We may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:

  - If the service is one that requires review by the *U.S. Food and Drug Administration* (FDA), it must be FDA-approved.

  - It must be performed by a Physician and in a facility with demonstrated experience and expertise.

  - The Covered Person must consent to the procedure acknowledging that we do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.

  - At least two studies must be available in published peer-reviewed medical literature that would allow us to conclude that the service is promising but unproven.

  - The service must be available from a Network Physician and/or a Network facility.

  For services provided outside the *United States*, if the service is one that requires review and approval by a governmental agency, then the service must be approved by that agency.

The decision about whether such a service can be deemed a Covered Health Service is solely at our discretion. Other apparently similar promising but unproven services may not qualify.

_____

(Name and Title)

NOTE: Product name of "Global Choice" filed as variable to allow name change in future.

[Global Choice]

United HealthCare Insurance Company

[Choice Plus]

Schedule of Benefits

[1]Include when Global Choice Benefits are available for Expatriates.

[2]Include when Global Choice Benefits are available for Inpatriates.

[3]Include when Global Choice Benefits are available for both Expatriates and Inpatriates.

[4]Include when International Benefits are available to Enrolled Dependents.

[[Global Choice] provides Benefits for Covered Health Services that are provided outside the *United States* to Subscribers who are *[[1]Expatriates]* [[3]or] *[[2]Inpatriates]* [[4]and to their Enrolled Dependents].] Benefits are available for Covered Health Services provided by or under the direction of a Physician both outside the *United States* and within the *United States*. The *Certificate of Coverage* (*Certificate*) describes Covered Health Services provided within the *United States*. The *[Global Choice] Rider* describes Covered Health Services provided outside the *United States*.

Include when Global Choice Benefits are available for Expatriates.

[1]Include if we or the group establish residency criteria for eligibility; include "s" if more than one day.

[An *Expatriate* is an Eligible Person who is resident outside the United States. If you cease to be resident outside the *United States,* you must notify the Enrolling Group and us immediately. [[1]You are considered to be resident outside the *United States* if you intend to make that locality your home for a period of [one - ten] [11 - 365] day[s] or longer.]]

Include when Global Choice benefits are available for Inpatriates.

[An *Inpatriate* is an Eligible Person who is a foreign national resident within the *United States*.]

Accessing Benefits

International Benefits apply to Covered Health Services that are provided by or under the direction of a Physician outside the *United States*.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the *United States*. For facility services, these are Benefits for Covered Health Services that are provided at a Network facility under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network anesthesiologist, Emergency room Physician, consulting Physician, pathologist and radiologist.

Non-Network Benefits apply to Covered Health Services that are provided within the *United States* by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility.

[1]Always include unless the Shared Savings Program does not apply to Benefits under this COC. "Shared Savings Program" is bracketed to accommodate possible name change.

Depending on the geographic area and the service you receive, you may have access [[1]through our [Shared Savings Program]] to non-Network providers who have agreed to discount their charges for

Covered Health Services. If you receive Covered Health Services from these providers, the Coinsurance will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less [[1]when you receive Covered Health Services from [Shared Savings Program] providers than from other non-Network providers] because the Eligible Expense may be a lesser amount.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under a UnitedHealthcare Policy. As a result, they may bill you for the entire cost of the services you receive.

If there is a conflict between this *Schedule of Benefits* and any summaries provided to you by the Enrolling Group, this *Schedule of Benefits* will control.

Additional information about the network of providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits*.

Pre-service Benefit Confirmation

We require notification before you receive certain Covered Health Services. In general, Network providers are responsible for notifying us before they provide these services to you. There are some Network Benefits, however, for which you are responsible for notifying us. Services for which you must provide pre-service notification are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

Note: Prior to implementation, the Project Team will determine if notification is required for services from international providers and for which services.

When you choose to receive certain Covered Health Services from [international or] non-Network providers, you are responsible for notifying us before you receive these services.

To notify us, call the telephone number for *Customer Care* on your ID card.

Covered Health Services which require pre-service notification:

- Ambulance - non-emergent air and ground.

Include when group purchases benefits for clinical trials.

- [Clinical trials.]

Include when group purchases benefits for accident-related dental services and notification is required.

- [Dental services - accidental.]
- Dental services - anesthesia and hospitalization.

Include when group does not purchase benefits for durable medical equipment.[1] Include if notification applies only to insulin pumps that exceed a specific dollar amount and insert appropriate dollar amount.

- [Diabetes equipment - insulin pumps [[1]over $[1,000 - 5,000]].]

Include when group purchases benefits for DME. [1]Include if notification applies only to DME that exceeds a specific dollar amount and insert appropriate dollar amount

- [Durable Medical Equipment [[1]over $[1,000 - 5,000]].]

Include when notification is required for home health care.

- [Home health care.]

Include when notification is required for hospice care.

- [Hospice care - inpatient.]

[1]Include when full maternity benefits are sold. [2]Include when complications of pregnancy benefits are sold.

- Hospital inpatient care - all scheduled admissions [[1]and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery] [[2]and stays for Complications of Pregnancy exceeding 96 hours for a cesarean section delivery].

Include when group purchases benefits for infertility services.

- [Infertility services.]
- In vitro fertilization services.

Include when notification is required for Lab/X-ray.

- [Lab, X-ray and diagnostics - sleep studies.]

Include when notification is required for Lab/X-ray-Major Diagnostics.

- [Lab, X-ray and major diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine.]

Include when group purchases benefits for musculoskeletal disorders.

- [Musculoskeletal disorders of the face, neck or head.]

Include when group purchases benefits for obesity surgery.

- [Obesity surgery.]

Include when notification is required for Pharmaceutical Products.

- [Pharmaceutical Products - IV infusions only.]

Include when group purchases benefits for prosthetics and notification is required. [1]Include if notification applies only to prosthetics that exceed a specific dollar amount and insert appropriate dollar amount

- [Prosthetic devices [[1]over $[1,000 - 5,000]].]

[1]Include when group purchases benefits for breast reduction surgery.

- Reconstructive procedures [[1], including breast reduction surgery].

Include when group purchases benefits for rehabilitation services and when notification is required for any service. [1]Include when Chiropractic Treatment is included in the rehabilitation services benefit.

- [Rehabilitation services [[1]and Chiropractic Treatment] - [physical therapy] [,] [and] [occupational therapy] [,] [and] [[1]Chiropractic Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [vision therapy].]

Include when notification is required for scopic procedures.

- [Scopic procedures - outpatient diagnostic and therapeutic.]
- Skilled Nursing Facility and Inpatient Rehabilitation Facility services.

Include when notification is required for outpatient surgeries.

- [Surgery - [all outpatient surgeries] [only for the following outpatient surgeries: [blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators]].]

Include when group purchases benefits for TMJ services.

- [Temporomandibular joint services.]

Include when notification is required for outpatient therapeutics.

- [Therapeutics - [all outpatient therapeutics] [only for the following services: [dialysis] [,] [and] [chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] hyperbaric oxygen therapy].]
- Transplants.

For all other services, when you choose to receive services from [international or] non-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Services. That's because in some instances, certain procedures may not meet the definition of a Covered Health Service and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By contacting us before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time notice is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

Include when group purchases benefits for mental health/substance abuse services and when prior authorization applies to any MH/SA benefit purchased.

[1]Include if prior authorization is required for International Benefits.

[Mental Health and Substance Abuse Services]

[Mental Health and Substance Abuse Services are not subject to the pre-service notification requirements described above. Instead, for [[1]*International*,] Network and Non-Network Benefits you must obtain prior authorization from the Mental Health/Substance Abuse Designee before you receive Mental Health Services and Substance Abuse Services. You can contact the Mental Health/Substance Abuse Designee at the telephone number on your ID card.]

Care Coordination[SM]

When we are notified as required, we will work with you to implement the Care Coordination[SM] process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the notification requirements described below do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to notify us before receiving Covered Health Services.

Benefits

Annual Deductibles are calculated on a [calendar] [Policy] year basis.

Out-of-Pocket Maximums are calculated on a [calendar] [Policy] year basis.

Include only when an Annual Maximum Benefit applies.

[The Annual Maximum Benefit is calculated on a [calendar] [Policy] year basis.]

When Benefit limits apply, the limit stated refers to any combination of *International Benefits*, Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a [calendar] [Policy] year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	
[1]Include when the Annual Deductible applies only to Non-Network Benefits. *[2]Include when an Outpatient Prescription Drug Rider is sold and the Annual Deductible applies to any combination of medical and RX benefits.* *[3]Include when the network and non-network amounts apply to the Network Annual Deductible.* The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive [[1]Non-Network] Benefits. [[2]The Annual Deductible applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Rider*.] [[3]The Annual Deductible for Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drug products provided under the *Outpatient Prescription Drug Rider*.] *Include when day/visit limits are reduced by the number of days/visit used toward meeting the deductible.* [Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible.] *Include when dollar limits are reduced by the amount used toward meeting the deductible.* [Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a dollar limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the amount used toward meeting the Annual Deductible.] *Include when the carry-over provision applies.* [Any amount you pay for medical expenses in the last three months of the previous year that is applied to the previous Annual Deductible will be carried over and applied to the current Annual Deductible. This carry-over feature applies only to the individual Annual Deductible.] *Include paragraph if the roll-over provision applies to a group in any circumstance.* [When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy.] *Include paragraph if the roll-over provision applies to a group*	*[1]Include separate International, Network and Non-Network headings and statements when Annual Deductible provision applies separately and delete the combined International, Network and Non-Network provision below.* ***[[1]International]*** *Include when separate individual and family deductibles apply (non-embedded).* [For single coverage, the Annual Deductible is $[0 - 15,000] per Covered Person. If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.] *Include when individual deductible applies (embedded).* [$[0 - 15,000] per Covered Person.] *Include when individual (with family maximum) deductible applies (embedded).* [$[0 - 15,000] per Covered Person, not to exceed $[0 - 45,000] for all Covered Persons in a family.] *Include when there is no annual deductible for International benefits.* [No Annual Deductible.] ***[[1]Network]*** *Include when separate individual and family deductibles apply (non-embedded).* [For single coverage, the Annual Deductible is $[0 - 15,000] per Covered Person. If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated

changing from a calendar year to Policy year plan.4[8]Include when this applies only to the individual deductible. [When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for medical expenses in the last three months of the previous calendar year that is applied to the previous Annual Deductible, will be rolled over and applied to the current Policy year Annual Deductible. This roll-over feature applies only to the first Policy year. [[4]This roll-over feature applies only to the individual Annual Deductible.]] The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. *Include only when a per occurrence deductible applies.* [The Annual Deductible does not include any applicable Per Occurrence Deductible.]	above does not apply. For family coverage, the family Annual Deductible is $[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.] *Include when individual deductible applies (embedded).* [$[0 - 15,000] per Covered Person.] *Include when individual (with family maximum) deductible applies (embedded).* [$[0 - 15,000] per Covered Person, not to exceed $[0 - 45,000] for all Covered Persons in a family.] *Include when there is no annual deductible for network benefits.* [No Annual Deductible.] ***[[1]Non-Network]*** *Include when separate individual and family deductibles apply (non-embedded).* [For single coverage, the Annual Deductible is $[0 - 15,000] per Covered Person. If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.] *Include when individual deductible applies (embedded).* [$[0 - 15,000] per Covered Person.] *Include when individual (with family maximum) deductible applies (embedded).* [$[0 - 15,000] per Covered Person, not to exceed $[0 - 45,000] for all Covered Persons in a family.] *Include when there is no annual deductible for non-network benefits.* [No Annual Deductible.] *[1]Include the combined International, Network and Non-Network heading and*

	statements when Annual Deductible provision applies to combined International, Network and Non-Network Benefits and delete the separate International, Network and Non-Network provisions above. ***[[1]International, Network and Non-Network]*** *Include when separate individual and family deductibles apply (non-embedded).* [For single coverage, the Annual Deductible is $[0 - 15,000] per Covered Person. If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.] *Include when individual deductible applies (embedded).* [$[0 - 15,000] per Covered Person.] *Include when individual (with family maximum) deductible applies (embedded).* [$[0 - 15,000] per Covered Person, not to exceed $[0 - 45,000] for all Covered Persons in a family.]
Include only when a per occurrence deductible applies. **[Per Occurrence Deductible]**	
[The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.]	***[International]*** *Include when a per occurrence deductible applies to inpatient hospital benefits.* [Hospital - Inpatient Stay: [$100 - 1,000] per day.] [Hospital - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] *Include when a per occurrence deductible applies to outpatient surgery benefits.* [Surgery - Outpatient: [$10 - 1,000] per date of service.]

	Include when a per occurrence deductible applies to inpatient transplant benefits. [Transplant - Inpatient Stay: [$100 - 1,000] per day.] [Transplant - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] ***[Network]*** *Include when a per occurrence deductible applies to inpatient hospital benefits.* [Hospital - Inpatient Stay: [$100 - 1,000] per day.] [Hospital - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] *Include when a per occurrence deductible applies to outpatient surgery benefits.* [Surgery - Outpatient: [$10 - 1,000] per date of service.] *Include when a per occurrence deductible applies to inpatient transplant benefits.* [Transplant - Inpatient Stay: [$100 - 1,000] per day.] [Transplant - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] ***[Non-Network]*** *Include when a per occurrence deductible applies to inpatient hospital benefits.* [Hospital - Inpatient Stay: [$100 - 1,000] per day.] [Hospital - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] *Include when a per occurrence deductible applies to outpatient surgery benefits.* [Surgery - Outpatient: [$50 - 800] per date of service.] *Include when a per occurrence deductible applies to inpatient transplant benefits.* [Transplant - Inpatient Stay: [$100 - 1,000] per day.]

	[Transplant - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.]
Out-of-Pocket Maximum	

[1]Include when OOPM includes the Annual Deductible.

[2]Include when OOPM includes the Per Occurrence Deductible.

[3]Include when OOPM includes Copayments.

[4]Include when an Outpatient Prescription Drug Rider is sold and the OOPM applies to any combination of medical and RX benefits.

[5]Include when the network and non-network amounts paid under the RX rider apply to the Network OOPM.

The maximum you pay per year for [[1]the Annual Deductible,] [[2]the Per Occurrence Deductible,] [[3]Copayments] [[1-2-3]or] Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. [[4]The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Rider*.] [[5]The Out-of-Pocket Maximum for Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drug products provided under the *Outpatient Prescription Drug Rider*.]

[6]Include only when the plan design does not apply all copayments and coinsurance to the OOPM.

[[6]Copayments and Coinsurance for some Covered Health Services will never apply to the Out-of-Pocket Maximum and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.] Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following:

- Any charges for non-Covered Health Services.

Include bullet if notification requirements apply to any benefit category in the Schedule of Benefits table and if the plan design supports not applying penalties to the OOPM.

- [The amount Benefits are reduced if you do not notify us as required.]
- Charges that exceed Eligible Expenses.
- Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.

Include bullet when an Outpatient Prescription Drug Rider is sold and copayments/coinsurance do not apply to the overall OOPM.

- [Copayments or Coinsurance for Covered Health Services provided under the *Outpatient Prescription*

[1]Include separate International, Network and Non-Network headings and statements when OOPM provision applies separately, and delete the combined International, Network and Non-Network provision below.

[[1]International]

Include when separate individual and family maximums apply (non-embedded).

[For single coverage, the Out-of-Pocket Maximum is $[0 - 45,000] per Covered Person.

If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $[0 - 135,000].]

Include when individual OOPM applies (embedded).

[$[0 - 45,000] per Covered Person.]

Include when individual (with family maximum) applies (embedded).

[$[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.]

Include when the OOPM includes the Annual Deductible.

[The Out-of-Pocket Maximum includes the Annual Deductible.]

Include when the OOPM does not include the Annual Deductible.

[The Out-of-Pocket Maximum does not include the Annual Deductible.]

Include when the OOPM includes the Per Occurrence Deductible.

[The Out-of-Pocket Maximum includes the Per Occurrence Deductible.]

Include when the OOPM does not include the Per Occurrence Deductible.

[The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.]

Include when there is no OOPM.

[No Out-of-Pocket Maximum.]

Drug Rider.]	***[[1]Network]***
	Include when separate individual and family maximums apply (non-embedded).
	[For single coverage, the Out-of-Pocket Maximum is $[0 - 45,000] per Covered Person. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $[0 - 135,000].]
	Include when individual OOPM applies (embedded).
	[$[0 - 45,000] per Covered Person.]
	Include when individual (with family maximum) applies (embedded).
	[$[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.]
	Include when the OOPM includes the Annual Deductible.
	[The Out-of-Pocket Maximum includes the Annual Deductible.]
	Include when the OOPM does not include the Annual Deductible.
	[The Out-of-Pocket Maximum does not include the Annual Deductible.]
	Include when the OOPM includes the Per Occurrence Deductible.
	[The Out-of-Pocket Maximum includes the Per Occurrence Deductible.]
	Include when the OOPM does not include the Per Occurrence Deductible.
	[The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.]
	Include when there is no OOPM.
	[No Out-of-Pocket Maximum.]
	[[1]Non-Network]
	Include when separate individual and family maximums apply (non-embedded).
	[For single coverage, the Out-of-Pocket

	Maximum is $[0 - 45,000] per Covered Person. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $[0 - 135,000].] *Include when individual OOPM applies (embedded).* [$[0 - 45,000] per Covered Person.] *Include when individual (with family maximum) applies (embedded).* [$[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.] *Include when the OOPM includes the Annual Deductible.* [The Out-of-Pocket Maximum includes the Annual Deductible.] *Include when the OOPM does not include the Annual Deductible.* [The Out-of-Pocket Maximum does not include the Annual Deductible.] *Include when the OOPM includes the Per Occurrence Deductible.* [The Out-of-Pocket Maximum includes the Per Occurrence Deductible.] *Include when the OOPM does not include the Per Occurrence Deductible.* [The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.] *Include when there is no OOPM.* [No Out-of-Pocket Maximum.] *[2]Include combined International, Network and Non-Network heading and statements below when OOPM provision applies to combined Benefits and delete the separate International, Network and Non-Network provisions above.* ***[[2]International, Network and Non-Network]*** *Include when separate individual and family maximums apply (non-*

	embedded). [For single coverage, the Out-of-Pocket Maximum is $[0 - 45,000] per Covered Person. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $[0 - 135,000].] *Include when individual OOPM applies (embedded).* [$[0 - 45,000] per Covered Person.] *Include when individual (with family maximum) applies (embedded).* [$[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.] *Include when the OOPM includes the Annual Deductible.* [The Out-of-Pocket Maximum includes the Annual Deductible.] *Include when the OOPM does not include the Annual Deductible.* [The Out-of-Pocket Maximum does not include the Annual Deductible.] *Include when the OOPM includes the Per Occurrence Deductible.* [The Out-of-Pocket Maximum includes the Per Occurrence Deductible.] *Include when the OOPM does not include the Per Occurrence Deductible.* [The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.] *Include when there is no OOPM.* [No Out-of-Pocket Maximum.]
Maximum Policy Benefit	

The maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Policy.	*[1]Include when separate International, Network and Non-Network Maximums apply.* ***[[1]International]*** [$[1,000,000 - 10,000,000] per Covered Person.] [No Maximum Policy Benefit.] ***[[1]Network]*** [$[1,000,000 - 10,000,000] per Covered Person.] [No Maximum Policy Benefit.] ***[[1]Non-Network]*** [$[1,000,000 - 10,000,000] per Covered Person.] [No Maximum Policy Benefit.] *[2]Include when combined International, Network and Non-Network Maximums applies.* ***[[2]International, Network and Non-Network]*** [$[1,000,000 - 10,000,000] per Covered Person.]
Include only when an annual maximum benefit applies. **[Annual Maximum Benefit]**	
[The maximum amount we will pay for Benefits during the year.]	*[1]Include when separate International, Network and Non-Network Maximums apply* ***[[1]International]*** [$[2,000 - 500,000] per Covered Person.] ***[[1]Network]*** [$[2,000 - 500,000] per Covered Person.] ***[[1]Non-Network]*** [$[2,000 - 500,000] per Covered Person.] *[2]Include when combined International, Network and Non-Network Maximums applies.* ***[[2]International, Network and Non-Network]*** [$[2,000 - 500,000] per Covered

	Person.]

Copayment
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.
Coinsurance
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Benefit Limits

Include when benefit plan design has no additional limits.

[This Benefit plan does not have Benefit limits in addition to those stated below within the Covered Health Service categories in the *Schedule of Benefits* table.]

Include when benefit plan design has limits for either orthopedic or spine surgery.

[In addition to the limits stated below within the Covered Health Service categories in the *Schedule of Benefits* table, the following limits apply:]

Include when orthopedic surgery is limited.

[1]*Include when orthopedic surgery is limited to a dollar amount per surgery.*

[2]*Include when orthopedic surgery is limited to a specific number of surgeries per lifetime.*

[3]*Include when orthopedic surgery is limited to both a dollar amount per surgery and a specific number of surgeries per lifetime.*

- [Benefits for Covered Health Services for orthopedic surgery for joint replacement are limited to [1a maximum of $[5,000 - 50,000] per surgery] [2[1 - 4] orthopedic [surgery] [surgeries] during the entire period of time a Covered Person is enrolled under the Policy] [3a maximum of $[5,000 - 50,000] per surgery, not to exceed [1 - 4] orthopedic [surgery] [surgeries] during the entire period of time a Covered Person is enrolled under the Policy].]

Include when spine surgery is limited.

[1]Include when spine surgery is limited to a dollar amount per surgery.

[2]Include when spine surgery is limited to a specific number of surgeries per lifetime.

[3]Include when spine surgery is limited to both a dollar amount per surgery and a specific number of surgeries per lifetime.

- [Benefits for non-emergent spine surgery, including all related services and devices, are limited to [1a maximum of $[5,000 - 75,000] per surgery] [2[1 - 4] spine [surgery] [surgeries] during the entire period of time a Covered Person is enrolled under the Policy] [3a maximum of $[5,000 - 75,000] per surgery, not to exceed [1 - 4] spine [surgery] [surgeries] during the entire period of time a Covered Person is enrolled under the Policy].

  This limit does not apply to:

  - Non-emergent surgeries for scoliosis or congenital defects.
  - Emergent surgeries for traumatic spine/spinal cord injury, spinal cord tumor, cauda equine syndrome, infection or neurological motor deficit.]

Include when benefits for spine surgery are provided only after conservative treatment is received.

- [Benefits for non-emergent spine surgery are available only after a Covered Person receives a minimum of a six-week course of conservative, non-surgical treatment provided under the supervision of a Physician. Benefits for spine surgery related to traumatic spine/spinal cord Injury, spinal cord tumor, cauda equine syndrome, infection, neurological motor deficit, scoliosis and congenital defects are not subject to this prior conservative, non-surgical treatment requirement.]

Note: Throughout schedule, variables are provided to require notification for International Benefits. Prior to implementation, the Project Team will determine which categories require notification for International Benefits.

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Include for groups that purchase benefits for acupuncture services. **1. [Acupuncture Services]**			
Include the limit selected by the group. [Limited to [10 - 100] visits per year.] [Limited to [10 - 100] visits per year, not to exceed $[100 - 5,000] in Eligible Expenses per year.] [Limited to $[100 - $5,000] in Eligible Expenses per year.] [This limit applies to *International* and Network Benefits only. Non-Network Benefits are not available.]	***[International]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] ***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
	[Non-Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]
[2.] Ambulance Services			
Pre-service Notification Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must notify us as soon as possible prior to transport. If you fail to notify us as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	***International***		

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Include the limit selected by the group. [Ground ambulance limited to $[500 - 5,000] per year.]	*Ground Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 300] per transport] [100% after you pay a Copayment of $[300 - 1,000] per day] [100% after you pay a Copayment of $[300 - 1,000] per day, up to a per day maximum of $[300 - 1,000]]	[Yes] [No]	[Yes] [No]
Include the limit selected by the group. [Air ambulance limited to $[1,000 - 10,000] per year.]	*Air Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 2,500] per transport] [100% after you pay a Copayment of $[2,500 - 10,000] per day] [100% after you pay a Copayment of $[2,500 - 10,000] per day, up to a per day maximum of $[2,500 - 10,000]]	[Yes] [No]	[Yes] [No]
	Network *Ground Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 300] per transport] [100% after you pay a Copayment of $[300 - 1,000] per	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	day] [100% after you pay a Copayment of $[300 - 1,000] per day, up to a per day maximum of $[300 - 1,000]] *Air Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 2,500] per transport] [100% after you pay a Copayment of $[2,500 - 10,000] per day] [100% after you pay a Copayment of $[2,500 - 10,000] per day, up to a per day maximum of $[2,500 - 10,000]] ***Non-Network*** Same as Network	[Yes] [No] Same as Network	[Yes] [No] Same as Network
Non-Emergency Ambulance Ground or air ambulance, as we determine appropriate.	***International*** *Ground Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 300] per transport] [100% after you pay a Copayment of $[300 - 1,000] per day] [100% after you pay a Copayment of $[300 - 1,000] per day, up to a per day maximum of $[300 -	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	1,000]] *Air Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 2,500] per transport] [100% after you pay a Copayment of $[2,500 - 10,000] per day] [100% after you pay a Copayment of $[2,500 - 10,000] per day, up to a per day maximum of $[2,500 - 10,000]]	[Yes] [No]	[Yes] [No]
	Network *Ground Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 300] per transport] [100% after you pay a Copayment of $[300 - 1,000] per day] [100% after you pay a Copayment of $[300 - 1,000] per day, up to a per day maximum of $[300 - 1,000]]	[Yes] [No]	[Yes] [No]
	Air Ambulance: [[50 - 100]%] [100% after you pay a Copayment of $[25 - 2,500] per transport] [100% after you pay a Copayment of	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	$[2,500 - 10,000] per day] [100% after you pay a Copayment of $[2,500 - 10,000] per day, up to a per day maximum of $[2,500 - 10,000]] ***Non-Network*** Same as Network	Same as Network	Same as Network
Include for groups that purchase benefits for clinical trials. **[3.] [Clinical Trials]**			
[Pre-service Notification Requirement] [You must notify us as soon as the possibility of participation in a clinical trial arises. If you don't notify us, you will be responsible for paying all charges and no Benefits will be paid.]			
[Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits*.] [Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)]	***[International]*** [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.] ***[Network]*** [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]		
	[Non-Network] [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]		
Include for groups that purchase benefits for accident-related dental services.			

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[4.] [Dental Services - Accident Only]			
Include when preservice notification is required. *[1]Include applicable reduction in Benefits or no Benefits.* **[Pre-service Notification Requirement]** [For [*International*,] Network and Non-Network Benefits you must notify us five business days before follow-up (post-Emergency) treatment begins. (You do not have to notify us before the initial Emergency treatment.) If you fail to notify us as required, [[1]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [[1]you will be responsible for paying all charges and no Benefits will be paid].]			
Include the limit selected by the group. *[1]Include when per tooth limits apply.* [Limited to $[2,000 - 5,000] per year.] [[1]Benefits are further limited to a maximum of $[500 - 1,500] per tooth.]	***[International]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] ***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
	[Non-Network] [Same as Network]	[Same as Network]	[Same as Network]
[5.] Diabetes Services *Diabetes Self-Management Training is mandated in Arkansas.*			
[1]Include when the durable medical equipment benefit is sold. *[2]Include when the durable medical equipment benefit is not sold.* *[3]Include when notification applies only to equipment that exceeds a minimum dollar amount and insert applicable dollar amount.* *[4]Include applicable reduction in Benefits or no Benefits.* **Pre-service Notification Requirement** For [*International* and] Non-Network Benefits you must notify us before obtaining any [[1]Durable Medical Equipment] [[2]diabetes equipment] for the management and treatment of diabetes [[3]that exceeds $[1,000 - 5,000] in cost (either purchase price or cumulative rental of a single item)]. If you fail to notify us as required, [[4]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [[4]you will be responsible for paying all charges and no Benefits will be paid].			

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	***International*** Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. ***Network*** Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. ***Non-Network*** Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items *Include when benefits for durable medical equipment are sold and when state law permits limits on diabetes equipment.* [Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under *Durable Medical Equipment*.] *Include only when benefits for durable medical equipment are sold and when state law does not permit limits on diabetes equipment.* [Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are not subject to the limit stated under *Durable Medical Equipment*.] *Include only when benefits for durable medical equipment are not sold and when benefits for insulin pumps are*	***International*** *[1]Include when both benefits for durable medical equipment and the outpatient prescription drug rider are sold.* [[1]Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Rider*.] *[2]Include when benefits for durable medical equipment are sold, but the outpatient prescription drug rider is not sold.* *[3]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[4]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[2]For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment*. For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [[3]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[4]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] *[5]Include when benefits for durable medical equipment are not sold and the outpatient prescription drug rider is sold.*		

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
limited. [Benefits for insulin pumps are limited to $[500 - 100,000] in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) every [year] [[two-five] years].]	*[6]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[7]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[5]For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [[6]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[7]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.] Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.] *[8]Include when neither benefits for durable medical equipment nor the outpatient prescription drug rider is sold.* *[9]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[10]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[8]For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [[9]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[10]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] ***Network*** *[1]Include when both benefits for durable medical equipment and the outpatient prescription drug rider are sold.* [[1]Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Rider*.] *[2]Include when benefits for durable medical equipment are sold, but the outpatient prescription drug rider is not sold.* *[3]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[4]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[2]For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment*. For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [[3]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[4]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[5]Include when benefits for durable medical equipment are not sold and the outpatient prescription drug rider is sold. *[6]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[7]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[5]For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [[6]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[7]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.] Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.] *[8]Include when neither benefits for durable medical equipment nor the outpatient prescription drug rider is sold.* *[9]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[10]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[8]For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [[9]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[10]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
	Non-Network *[1]Include when both benefits for durable medical equipment and the outpatient prescription drug rider are sold.* [[1]Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Rider*.] *[2]Include when benefits for durable medical equipment are sold, but the outpatient prescription drug rider is not sold.* *[3]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[4]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[2]For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment*. For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [[3]and Benefits [are] [are not] subject to payment of		

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	the Annual Deductible]. [[4]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] *[5]Include when benefits for durable medical equipment are not sold and the outpatient prescription drug rider is sold.* *[6]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[7]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[5]For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [[6]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[7]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.] Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.] *[8]Include when neither benefits for durable medical equipment nor the outpatient prescription drug rider is sold.* *[9]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[10]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[8]For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [[9]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[10]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
Include for groups that purchase benefits for DME. **[6.] [Durable Medical Equipment]**			
[1]Include when notification applies only to DME that exceeds a minimum dollar amount and insert applicable dollar amount. *[2]Include applicable reduction in Benefits or no Benefits.* **[Pre-service Notification Requirement]** [For [*International* and] Non-Network Benefits you must notify us before obtaining any Durable Medical Equipment [[1]that exceeds $[1,000 - 5,000] in cost (either purchase price or cumulative rental of a single item)]. If you fail to notify us as required, [[2]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [[2]you will be responsible for paying all charges and no Benefits will be paid].]			
Include the limit selected by the group. *[1]Include either option as standard plan*	***[International]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
design. [[1]Limited to $[500 - 100,000] in Eligible Expenses per year. Benefits are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two-five] years].] [[1]Limited per year as follows: • [$[500 - 10,000] in Eligible Expenses for Tier 1.Tier 1 includes disposable supplies necessary for the effective use of covered Durable Medical Equipment.] • [$[10,001 - 25,000] in Eligible Expenses for Tier 2.] • [$[25,001 - 100,000] in Eligible Expenses for Tier 3.] These Tier limits include repair. Benefits for replacement are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two-five] years].] *Always include when the DME benefit is sold.* [To receive Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.]	***[Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[Non-Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
[7.] Emergency Health Services - Outpatient			
Include when benefit is limited. [Limited to $[100 - 5,000] per year.] **Note:** If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within one business	***International*** [[50 - 100]%] *Include bracketed provision and select either #1 or #2 if the*	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date we decide a transfer is medically appropriate, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service. *Include when covered health services performed at an emergency room are subject to the copayments/coinsurance stated under other benefit categories, in addition to the outpatient emergency copayment stated in this section. (This will not apply when the emergency benefit is subject to coinsurance only.)* [In addition to the Copayment stated in this section, the Copayments/Coinsurance for the following services apply when the Covered Health Service is performed as an Emergency Health Service: • [Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*.] • [Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient*.] • [Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*.] • [Outpatient surgery procedures described under *Surgery - Outpatient*.]	*copayment is waived.* *[1]Include as standard; [2]Include only to match prior benefit plans.* [100% after you pay a Copayment of $[5 - 300] per visit. [If you are admitted as an inpatient to a Network Hospital [[1]directly from the Emergency room] [[2]within 24 hours of receiving outpatient Emergency treatment for the same condition], you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.]] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year.] [100% after you pay a Copayment of $[5 - 300] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year.]		

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
• [Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.] *[1]Include bracketed reference to chiropractic treatment when chiropractic treatment benefits are sold.* • [Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy [[1]and Chiropractic Treatment]*.]]	***Network*** [[50 - 100]%] *Include bracketed provision and select either #1 or #2 if the copayment is waived.* *[1]Include as standard; [2]Include only to match prior benefit plans.* [100% after you pay a Copayment of $[5 - 300] per visit. [If you are admitted as an inpatient to a Network Hospital [[1]directly from the Emergency room] [[2]within 24 hours of receiving outpatient Emergency treatment for the same condition], you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.]] [100% for the first [2 -	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	10] visits in a year; [50 - 90]% for any subsequent visits in that year.] [100% after you pay a Copayment of $[5 - 300] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year.]		
	Non-Network Same as Network	Same as Network	Same as Network
Include for groups that purchase hearing aid benefits. **[8.] [Hearing Aids]**			
Include the limit selected by the group. [Limited to $[500 - 5,000] per year.] [Limited to $[500 - 5,000] for each hearing impaired ear every [24 - 36] months.] [Limited to $[500 - 25,000] per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy.]	***[International]*** [[50 - 100]%] ***[Network]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
	[Non-Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
[9.] Home Health Care			

Include if pre-service notification is required.

[1]*Include applicable reduction in Benefits.*

[Pre-service Notification Requirement]

[For [*International* and] Non-Network Benefits you must notify us five business days before receiving services or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.]

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Include the limit selected by the group. [Limited to [40 - 200] visits per year. One visit equals up to four hours of skilled care services.] [Limited to $[500 - 5,000] per year.] [Limited to [40 - 200] visits per year to a maximum of $[500 - 5,000] in Eligible Expenses per year.] [Network Benefits are limited to [40 - 200] visits per year and Non-Network Benefits are limited to [40 - 200] visits per year. One visit equals up to four hours of skilled care services.] *Include when infusion administration only is not included in the limit.* [This visit limit does not include any service which is billed only for the administration of intravenous infusion.]	***International*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 50] per visit] ***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 50] per visit]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 50] per visit] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]
[10.] Hospice Care			
Include if pre-service notification is required. [1]*Include applicable reduction in Benefits.* **[Pre-service Notification Requirement]** [For [*International* and] Non-Network Benefits you must notify us five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to notify us as			

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.] *Include if pre-admission notification is required.* [In addition, for Non-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.]			
	International [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per day] ***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per day]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per day] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]
[11.] Hospital - Inpatient Stay			
[1]*Include applicable Benefit level.* **Pre-service Notification Requirement** For [*International* and] Non-Network Benefits for a scheduled admission, you must notify us five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses. *Include if pre-admission notification is required.* [In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]			
	International [[50 - 100]%]	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay]		[Yes, after the Per Occurrence Deductible is satisfied]
	Network		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay]		[Yes, after the Per Occurrence Deductible is satisfied]
	Non-Network		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per		[Yes, after the Per Occurrence Deductible is satisfied]

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay]		
Include for groups that purchase infertility benefits. **[[12]. Infertility Services]**			
When this benefit is purchased, pre-service notification will always be required. [1]Include applicable reduction in Benefits or no Benefits. **[Pre-service Notification Requirement]** [You must notify us as soon as the possibility of the need for Infertility Services arises. If you fail to notify us as required, [[1]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [[1]you will be responsible for paying all charges and no Benefits will be paid].]			
Include the limit selected by the group. *[1]Include when the maximum benefit is combined with infertility drugs under the RX rider.* [Limited to $[2,000 - 30,000] per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. [[1]This limit includes Benefits for infertility medications provided under the *Outpatient Prescription Drug Rider*.]]	***[International]*** [[50 - 100]%] ***[Network]*** [[50 - 100]%] ***[Non-Network]*** [[50 - 100]%] [Non-Network Benefits are not available.]	[Yes] [No] [Yes] [No] [Yes] [No] [Non-Network Benefits are not available.]	[Yes] [No] [Yes] [No] [Yes] [No] [Non-Network Benefits are not available.]
[13.] Lab, X-Ray and Diagnostics - Outpatient			

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Include when pre-service notification is required for sleep studies. *[1]Include applicable reduction in Benefits.* **[Pre-service Notification Requirement]** [For [*International* and] Non-Network Benefits for sleep studies, you must notify us five business days before scheduled services are received. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.]			
Include limit selected by group. [Limited to $[100 - 5,000] per year.] [Non-Network Benefits are limited to $[100 - 5,000] per year.]	***International*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service] ***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service]	[Yes] [No] [Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes] [No]
[14.] Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
Include when pre-service notification is required for CT, PET, MRI, MRA and nuclear medicine. *[1]Include applicable reduction in Benefits.* **[Pre-service Notification Requirement]** [For [*International* and] Non-Network Benefits you must notify us five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.]			
Include limit selected by group. [Limited to $[100 - 5,000] per year.] [Non-Network Benefits are limited to $[100 - 5,000] per year.]	***International*** [[50 - 100]%] [100% after you pay a Copayment of $[25 - 500] per service]	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Network [[50 - 100]%] [100% after you pay a Copayment of $[25 - 500] per service] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[25 - 500] per service]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
Include for groups that purchase inpatient and intermediate mental health/substance abuse benefits. This is a mandated offer in Arkansas. If the employer chooses not to have this benefit, they must refuse this benefit in writing. Remove entire benefit if group purchases MH full parity. **[[15.] Mental Health and Substance Abuse Services - Inpatient and Intermediate]**			
When this benefit is purchased, prior authorization will always be required. **[Prior Authorization Requirement]** [For [*International*,] Network and Non-Network Benefits you must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.]			
Include the limit selected by the group. [Limited to [10 - 100] days per year.] [Non-Network Benefits for Mental Health and Substance Abuse Services are limited to [10 - 100] days per year.] [Non-Network Benefits for Mental Health Services are limited to [10 - 100] days per year.] [Non-Network Benefits for Substance Abuse Services are limited to [10 - 100] days per year.] [Mental Health Services are limited to	***[International]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[10 - 100] days per year.] [Substance Abuse Services are limited to [10 - 100] days per year.]	$[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay] ***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No]
	[Non-Network] [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No]
Include for groups that purchase outpatient mental health/substance			

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
abuse benefits. This is a mandated offer in Arkansas. If the employer chooses not to have this benefit, they must refuse this benefit in writing. Remove entire benefit if group purchases MH full parity. **[[16.] Mental Health and Substance Abuse Services - Outpatient]**			
Include authorization language only for groups that elect the "Employer Coverage" option. Delete authorization language for groups that elect the "National Service Center" option. **[Prior Authorization Requirement]** [For [*International*,] Network and Non-Network Benefits you must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.]			
Include the limit selected by the group. [Limited to [10 - 100] visits per year.] [Non-Network Benefits for Mental Health and Substance Abuse Services are limited to [10 - 100] visits per year.] [Non-Network Benefits for Mental Health Services are limited to [10 - 100] visits per year.] [Non-Network Benefits for Substance Abuse Services are limited to [10 - 100] visits per year.] [Mental Health Services are limited to [10 - 100] visits per year.] [Substance Abuse Services are limited to [10 - 100] visits per year.]	***[International]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [100% after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit] ***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [100% after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[Non-Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [100% after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit]	[Yes] [No]	[Yes] [No]
Include for groups that purchase benefits for obesity surgery. **[[17.] Obesity Surgery]**			
When this benefit is purchased, pre-service notification will always be required. [1]*Include applicable Benefit level.* **[Pre-service Notification Requirement]** [You must notify us [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.] *Include if pre-admission notification is required.* [In addition, for [*International* and] Non-Network Benefits you must contact us 24 hours before admission for an Inpatient Stay.] **[It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.]**			
[1]*Insert the limit selected by the group.* [Any combination of *International*, Network and Non-Network Benefits is limited to $[[1]50,000 - 250,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy. Non-Network Benefits are further limited to $[[1]5,000 - 30,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy.]	***[International]*** [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.] ***[Network]*** [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each		

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Covered Health Service category in this *Schedule of Benefits*.] ***[Non-Network]*** [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]		
Include if group purchases benefits for ostomy supplies. **[[18.] Ostomy Supplies]**			
Include the limit selected by the group. [Limited to $[500 - 25,000] per year.]	***[International]*** [[50 - 100]%] ***[Network]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
	[Non-Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
[19.] Pharmaceutical Products - Outpatient			
Include when notification is required for IV infusions. *[1]Include applicable reduction in Benefits.* **[Pre-service Notification Requirement]** [For [*International* and] Non-Network Benefits you must notify us five business days before scheduled intravenous infusions are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.]			
Include limit selected by group. [Limited to $[100 - 5,000] per year.] [Non-Network Benefits are limited to $[100 - 5,000] per year.]	***International*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per Pharmaceutical Product] *Include when coinsurance is tiered and select the appropriate number of tiers by plan*	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	design. [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6] ***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per Pharmaceutical Product] *Include when coinsurance is tiered and select the appropriate number of tiers by plan design.* [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per Pharmaceutical Product] *Include when coinsurance is tiered and select the appropriate number*	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	of tiers by plan design. [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6]		
[20.] Physician Fees for Surgical and Medical Services			
	International [50 - 100]% ***Network*** [50 - 100]% ***Non-Network*** [50 - 100]%	 [Yes] [No] [Yes] [No] [Yes] [No]	 [Yes] [No] [Yes] [No] [Yes] [No]
[21.] Physician's Office Services - Sickness and Injury			
Include if group chooses to limit benefit. [1]Insert limit selected by group [Limited to [[1]2 - 10] visits per year.] *Include when covered health services performed in a physician's office are subject to the copayments/coinsurance stated under other benefit categories, in addition to the office visit copayment stated in this section. (This will not apply when the office visit benefit is subject to coinsurance only.)* [In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance for the following services apply when the Covered Health Service is performed in a Physician's office: • [Lab, radiology/X-rays and other	***International*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 100] per visit for a Specialist Physician office visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit; [50 -	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*.] • [Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient*.] • [Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*.] • [Outpatient surgery procedures described under *Surgery - Outpatient*.] • [Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.] *[1]Include bracketed reference to chiropractic treatment when chiropractic treatment benefits are sold.* • [Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy [[1]and Chiropractic Treatment]*.]]	100]% for a Specialist Physician office visit] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 100] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] ***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 100] per visit for a Specialist Physician	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	office visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 100] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 100] per visit for a Specialist Physician office visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	office visit; [50 - 100]% for a Specialist Physician office visit] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 100] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year]		
[22.] Pregnancy - Maternity Services			
Pre-service Notification Requirement [1]*Include applicable reduction in Benefits.* For [*International* and] Non-Network Benefits you must notify us as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses. **It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.**			
	International [1]*Include when an annual deductible applies to international benefits.* [2]*Include when International services in the Physician's office are subject to a Copayment.* Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* [[1]except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's		

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	length of stay]. [[2]For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.] ***Network*** *[1]Include when an annual deductible applies to network benefits.* *[2]Include when Network services in the Physician's office are subject to a Copayment.* Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* [[1]except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay]. [[2]For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.] ***Non-Network*** *[1]Include when an annual deductible applies to non-network benefits.* *[2]Include when Non-Network services in the Physician's office are subject to a Copayment.* Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* [[1]except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay]. [[2]For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.]		
[23.] Preventive Care Services			
Include when preventive care is limited and select the limit that applies. [Preventive care services are limited to $[100 - 1,000] per year.] **Physician office services** [Limited to [2 - 10] visits per year.] Well baby and well child care includes, but not limited to, 20 visits at approximately the following age intervals: birth, two weeks, two months, four months, six months, nine months, 12 months, 15 months, 18 months, two	***International*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 100] per visit for a Specialist Physician	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
years, three years, four years, five years, six years, eight years, 10 years, 12 years, 14 years, 16 years, and 18 years. No Copayment, Coinsurance or Deductible will be applicable to Network or Non-Network children's immunizations.	office visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] ***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 100] per visit for a Specialist Physician office visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] ***Non-Network*** [[50 - 100]%] [100% after you pay	[Yes] [No] [Yes] [No] [Non-Network	[Yes] [No] [Yes] [No] [Non-Network

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	a Copayment of $[5 - 75] per visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 100] per visit for a Specialist Physician office visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [Non-Network Benefits are not available except for children under the age of 19.]	Benefits are not available except for children under the age of 19.]	Benefits are not available except for children under the age of 19.]
Lab, X-ray or other preventive tests:	***International*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service]	[Yes] [No]	[Yes] [No]
	Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service]	[Yes] [No]	[Yes] [No]
	Non-Network [[50 - 100]%] [100% after you pay	[Yes] [No] [Non-Network	[Yes] [No] [Non-Network

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	a Copayment of $[5 - 100] per service] [Non-Network Benefits are not available except for children under the age of 19.]	Benefits are not available except for children under the age of 19.]	Benefits are not available except for children under the age of 19.]
Include when group purchases benefits for prosthetic devices. **[24.] [Prosthetic Devices]**			
Include if notification is required. *[1]Include when notification applies only to prosthetics that exceed a minimum dollar amount and insert applicable dollar amount.* *[2]Include applicable reduction in Benefits or no Benefits.* **[Pre-service Notification Requirement]** [For [*International* and] Non-Network Benefits you must notify us before obtaining prosthetic devices [[1]that exceed $[1,000 - 5,000] in cost per device]. If you fail to notify us as required, [[2]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [[2]you will be responsible for paying all charges and no Benefits will be paid].]			
Include the limit selected by the group. *[1]Include either option as standard.* [[1]Limited to $[2,500 - 100,000] per year. Benefits are limited to a single purchase of each type of prosthetic device every [year] [[two-five] years].] [[1]Limited per year as follows: • A maximum of $[10,000 - 30,000] per body part for each arm, leg, hand or foot. • A maximum of $[5,000 - 15,000] per body part for each eye, ear, nose, face, breast, speech aid prosthetics or tracheo-esophageal voice prosthetics. These limits include repair. Benefits for replacement are limited to a single purchase of each type of prosthetic device every [year] [[two-five] years].	***[International]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
Always include statement below except when prosthetics are not limited. [Once this limit is reached, Benefits continue to be available for items required by the Women's Health and Cancer Rights Act of 1998.]	***[Non-Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
[25.] Reconstructive Procedures			

[1]*Include applicable Benefit level.*

Pre-service Notification Requirement

For [*International* and] Non-Network Benefits you must notify us five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.

Include if pre-admission notification is required.

[In addition, for [*International* and] Non-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).]

International

Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.

Include when group does not purchase benefits for prosthetic devices.

[1]Include when sold with a plan that has an annual deductible and select either "are" or "are not."

[2]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."

[For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [[1]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[2]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]

Network

Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Health Service category in this *Schedule of Benefits*. *Include when group does not purchase benefits for prosthetic devices.* *[1]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[2]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [[1]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[2]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
	Non-Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. *Include when group does not purchase benefits for prosthetic devices. The Benefit level inserted here must be the same as the plan coinsurance level.* *[1]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[2]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [[1]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[2]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
Include entire section when rehabilitation services benefit is sold. *[1]Include when Chiropractic Treatment benefits are sold.* **[[26.] Rehabilitation Services - Outpatient Therapy [[1]and Chiropractic Treatment]]**			
Include when notification is required for any rehabilitation service. *[1]Include applicable Benefit level.* **[Pre-service Notification Requirement]**			

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[For [*International* and] Non-Network Benefits you must notify us five business days before receiving [physical therapy] [,] [and] [occupational therapy] [,] [and] [Chiropractic Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [vision therapy] or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.]			
Include when per therapy limits apply. *[1]Include when Chiropractic Treatment benefits are sold. Select either visit or dollar limits as applicable.* *[2]Include when vision therapy benefits are sold.* [Limited per year as follows: • [10-100] visits of physical therapy. • [10-100] visits of occupational therapy. • [[1][10-100] visits of Chiropractic Treatment.] • [[1]$[300 - 1,000] of Chiropractic Treatment.] • [10-100] visits of speech therapy. • [10-100] visits of pulmonary rehabilitation therapy. • [10-100] visits of cardiac rehabilitation therapy. • [10-100] visits of post-cochlear implant aural therapy. • [[2][10-100] visits of vision therapy.]]	***[International]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit]	[Yes] [No]	[Yes] [No]
Include when combined therapy visit limits apply. [Any combination of outpatient rehabilitation services is limited to [10 - 160] visits per year.] *Include when combined therapy dollar limits apply.* [Any combination of outpatient	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit]	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
rehabilitation services is limited to $[750 - 12,000] per year.] *Include when combined therapy visit limits apply separately to network benefits and to non-network benefits.* [Network Benefits for any combination of outpatient rehabilitation services are limited to [10 - 160] visits per year. Non-Network Benefits for any combination of outpatient rehabilitation services are limited to [10 - 160] visits per year.]			
	[Non-Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit]	[Yes] [No]	[Yes] [No]
[27.] Scopic Procedures - Outpatient Diagnostic and Therapeutic			
Include when notification is required for scopic procedures. *[1]Include applicable Benefit level.* **[Pre-service Notification Requirement]** [For [*International* and] Non-Network Benefits you must notify us five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.]			
	International [50 - 100]% ***Network*** [50 - 100]% ***Non-Network*** [50 - 100]%	[Yes] [No] [Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes] [No]
[28.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
[1]Include applicable Benefit level.			

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Pre-service Notification Requirement For [*International* and] Non-Network Benefits for a scheduled admission, you must notify us five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses. *Include if pre-admission notification is required.* [In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]			
Include limit selected by group. [Limited to [40 - 180] days per year.] [*International Benefits* are limited to [40 - 180] days per year. Network Benefits are limited to [40 - 180] days per year. Non-Network Benefits are limited to [40 - 180] days per year.]	***International*** [[50 - 100]%] [100% after you pay a Copayment of $[50 - 1,000] per day] *Copayment option below identified as #1 to be tied only to either of the options #1 below with an Inpatient Stay maximum.* [[1]100% after you pay a Copayment of $[50 - 2,000] per Inpatient Stay] [[1]100% after you pay a Copayment of $[50 - 1,000] per day to a maximum Copayment of $[50 - 5,000] per Inpatient Stay] *Variable #1 can be used only with options numbered #1 above.* [[1]If you are transferred to a Skilled Nursing Facility or Inpatient Rehabilitation Facility directly from an acute	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	facility, any combination of Copayments required for the Inpatient Stay in a Hospital and the Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility will apply to the stated maximum Copayment per Inpatient Stay.] [No Copayment applies if you are transferred to a Skilled Nursing Facility or Inpatient Rehabilitation Facility directly from an acute facility.] ***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[50 - 1,000] per day] *Copayment option below identified as #1 to be tied only to either of the options #1 below with an Inpatient Stay maximum.* [[1]100% after you pay a Copayment of $[50 - 2,000] per Inpatient Stay] [[1]100% after you pay a Copayment of $[50 - 1,000] per day to a maximum Copayment of $[50 - 5,000] per Inpatient	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Stay] *Variable #1 can be used only with options numbered #1 above.* [[1]If you are transferred to a Skilled Nursing Facility or Inpatient Rehabilitation Facility directly from an acute facility, any combination of Copayments required for the Inpatient Stay in a Hospital and the Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility will apply to the stated maximum Copayment per Inpatient Stay.] [No Copayment applies if you are transferred to a Skilled Nursing Facility or Inpatient Rehabilitation Facility directly from an acute facility.]		
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of $[50 - 1,000] per day] [100% after you pay a Copayment of $[50 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[50	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	- 1,000] per day to a maximum Copayment of $[50 - 10,000] per Inpatient Stay]		
[29.] Surgery - Outpatient			
Include when notification is required. *[1]Include applicable Benefit level.* **[Pre-service Notification Requirement]** [For [*International* and] Non-Network Benefits [for all outpatient surgeries] [for [blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators]] you must notify us five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
	International [[50 - 100]%] [100% after you pay a Copayment of $[10 - 1,000] per date of service] [100%after you pay a Copayment of $[10 - 1,000] per date of service, to a maximum Copayment of $[10 - 5,000] per year]] ***Network*** [[50 - 100]%] [[100% after you pay a Copayment of $[10 - 1,000] per date of service] [100% after you pay a Copayment of $[10 - 1,000] per date of service, to a maximum	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied] [Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Copayment of $[10 - 5,000] per year]] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[10 - 1,000] per date of service] [100% after you pay a Copayment of $[10 - 1,000] per date of service, to a maximum Copayment of $[10 - 5,000] per year]]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]
Include when group purchases TMJ benefit. **[[30.] Temporomandibular Joint Services]**			
When this benefit is purchased, pre-service notification will always be required. *[1]Include applicable Benefit level.* **[Pre-service Notification Requirement]** [For [*International* and] Non-Network Benefits you must notify us five business days before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.] *Include if pre-admission notification is required.* [In addition, for [*International* and] Non-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions.]			
Include the limit selected by the group. [Limited to $[1,000 - 20,000] per year.]	***[International]*** [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]		
	[Network] [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]		
	[Non-Network]		

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]		
[31.] Therapeutic Treatments - Outpatient			
Include when notification is required. [1]*Include applicable Benefit level.* **[Pre-service Notification Requirement]** [For [*International* and] Non-Network Benefits you must notify us [for all outpatient therapeutic services] [for the following outpatient therapeutic services] five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. [Services that require notification: [dialysis] [,] [and] chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [hyperbaric oxygen therapy].] If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.]			
	International [[50 - 100]%] [100% after you pay a Copayment of $[25 - 100] per treatment] ***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[25 - 100] per treatment] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[25 - 100] per treatment]	[Yes] [No] [Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes] [No]
[32.] Transplantation Services			
[1]*Include if Non-Network Benefits are sold.* **Pre-service Notification Requirement** For [*International* and] Network Benefits you must notify us as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't notify us and if, as a result, the services are not performed at a Designated Facility, [*International* and] Network Benefits will not be paid. [[1]Non-Network Benefits will apply.]			

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[2]*Include applicable benefit reduction penalty.* [[1]For Non-Network Benefits you must notify us as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you fail to notify us as required, Benefits will be reduced to [[2]50 - 95]% of Eligible Expenses.] *Include if Non-Network Benefits are sold and pre-admission notification is required.* [In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]			
For [*International* and] Network Benefits, transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive [*International* or] Network Benefits. *Include when Non-Network Benefits are limited and insert the limit selected by the group.* [Non-Network Benefits are limited to $[30,000 - 250,000] per transplant.]	***International*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay] ***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 -	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied] [Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	5,000] per Inpatient Stay]		
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied] [Non-Network Benefits are not available.]
[33.] Urgent Care Center Services			
Include when urgent care services are limited and insert the limit selected by the group. [Limited to $[100 - 5,000] per year.] [Limited to [2 - 10] visits per year.] *Include when covered health services performed at an urgent care center are subject to the copayments/coinsurance stated under other benefit categories, in addition to the urgent care copayment stated in this section. (This will not apply when the urgent care benefit is subject to coinsurance only.)* [In addition to the Copayment stated in this section, the Copayments/Coinsurance for the following services apply when the	***International*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit to a maximum Copayment of $[5 - 5,000] per year] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Covered Health Service is performed at an Urgent Care Center: • [Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*.] • [Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient*.] • [Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*.] • [Outpatient surgery procedures described under *Surgery - Outpatient*.] • [Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.] *[1]Include bracketed reference to chiropractic treatment when chiropractic treatment benefits are sold.* • [Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy [[1]and Chiropractic Treatment].*]**]**	a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] ***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit to a maximum	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Copayment of $[5 - 5,000] per year] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year]		
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit to a maximum Copayment of $[5 - 5,000] per year] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year]	[Yes] [No]	[Yes] [No]
Include when group purchases benefits for vision exams. **[[34.] Vision Examinations]**			

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[Limited to [1 exam] [[2-3] exams] per year.] [Limited to [1 exam] [[2-3] exams] every [2 - 3] years.]	***[International]*** [[50 - 100]%] [100% after you pay a Copayment of [$5 - 75] per visit] ***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of [$5 - 75] per visit]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
	[Non-Network] [[50 - 100]%] [100% after you pay a Copayment of [$5 - 75] per visit] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]
Include when group purchases benefits for wigs. **[[35.] Wigs]**			
Include the limit selected by the group. [Limited to $[100 - 1,000] per year.] [Limited to $[100 - 5,000] every [24 - 36] months.]	***[International]*** [[50 - 100]%] ***[Network]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
	[Non-Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
Additional Benefits Required By Arkansas Law			
[36.] Dental Services -Anesthesia and Hospitalization			

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Pre-service Notification Requirement Any applicable notification requirements will be the same as those stated under Hospital - Inpatient Stay in this Schedule of Benefits.			
	[[1]Designated Network] [Benefits will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.]		
	Network Benefits will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.		
	Non-Network Benefits will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.		
[37.] In Vitro Fetilization Services			
[1]*Include applicable reduction in Benefits or no Benefits.* **Pre-service Notification Requirement** You must notify us as soon as the possibility of the need for in vitro fertilization arises. If you fail to notify us as required, [[1]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [[1]you will be responsible for paying all charges and no Benefits will be paid].			
Limited to a lifetime maximum of $15,000.	***International*** [50 - 100%] [*International Benefits* are not available.] ***Network*** [50 - 100%] ***Non-Network*** [50 - 100%]	[Yes] [No] [*International Benefits* are not available.] [Yes] [No] [Yes] [No]	[Yes] [No] [*International Benefits* are not available.] [Yes] [No] [Yes] [No]
[38.] Medical Foods			
	International [50 - 100%] [*International Benefits* are not available.]	[Yes] [No] [*International Benefits* are not	[Yes] [No] [*International Benefits* are not

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
		available.]	available.]
	[1]Include when group purchases the Outpatient Prescription Drug Rider.	[Yes] [No]	[Yes] [No]
	Network		
	Depending upon where the Covered Health Service is provided, Benefits will be [50 - 100]% [[1]or as provided under the *Outpatient Prescription Drug Rider*].		
	Non-Network		
	Same as Network	Same as Network	Same as Network
Include ONLY when group purchases plan with MH full parity. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. **[[39.] Mental Health Services - Inpatient and Intermediate]**			
[Prior Authorization Requirement] [You must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.]			
	International		
	[50 - 100%]	[Yes] [No]	[Yes] [No]
	[*International Benefits* are not available.]	[*International Benefits* are not available.]	[*International Benefits* are not available.]
Limited to [10-100] days per year.]	***Network***		
[Non-Network Benefits are limited to [10-100] days per year.]	[50 - 100%]	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Non-Network [50 - 100%]	[Yes] [No]	[Yes] [No]
[[40.] Mental Health Services - Outpatient]			
When this benefit is purchased, prior authorization will always be required. **[Prior Authorization Requirement]** [You must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.]			
	International [50 - 100%] [*International Benefits* are not available.]	[Yes] [No] [*International Benefits* are not available.]	[Yes] [No] [*International Benefits* are not available.]
	[*Network* Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.**]** **[*Non-Network*** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.**]**		
[41.] Musculoskeletal Disorders of the Face, Neck or Head]			
[Pre-service Notification Requirement] [Depending upon where the Covered Health Service is provided, any applicable notification or authorization requirements will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]			
	International [50 - 100%] [*International Benefits* are not available.]	[Yes] [No] [*International Benefits* are not available.]	[Yes] [No] [*International Benefits* are not available.]
[Depending upon the Covered Health Service, Benefit limits are the same as	***[Network]*** [Depending upon where the Covered Health Service is		

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
those stated under the specific Benefit category in this *Schedule of Benefits*.] [Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits*.]	provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.] ***[Non-Network]*** [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]		
Include ONLY when group purchases plan with inpatient/intermediate SA benefits with MH full parity or no MH. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. **[42.] Substance Abuse Services - Inpatient and Intermediate]**			
When this benefit is purchased, prior authorization will always be required. **[Prior Authorization Requirement]** [You must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.]			
[Limited to [10-100] days per year.] [Non-Network Benefits are limited to [10-100] days per year.]	***International*** [50 - 100%] [*International Benefits* are not available.] ***Network*** [50 - 100%] ***Non-Network*** [50 - 100%]	[Yes] [No] [*International Benefits* are not available.] [Yes] [No] [Yes] [No]	[Yes] [No] [*International Benefits* are not available.] [Yes] [No] [Yes] [No]
Include ONLY when group purchases plan with inpatient/intermediate SA benefits with MH full parity or no MH. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. **[43.] Substance Abuse Services -**			

When Benefit limits apply, the limit refers to any combination of International Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Outpatient			
When this benefit is purchased, prior authorization will always be required. **[Prior Authorization Requirement]** [You must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.]			
	International [50 - 100%] [*International Benefits* are not available.]	[Yes] [No] [*International Benefits* are not available.]	[Yes] [No] [*International Benefits* are not available.]
[Limited to [10-100] days per year.] [Non-Network Benefits are limited to [10-100] days per year.]	***Network*** [50 - 100%]	[Yes] [No]	[Yes] [No]
	Non-Network [50 - 100%]	[Yes] [No]	[Yes] [No]

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines.

When Covered Health Services are received from a provider outside the *United States*, Eligible Expenses are determined, at our discretion, based on:

- Any applicable contracted fee(s) with that provider.
- Charges that are representative of the average and prevailing charge for the same health service in the same or similar geographic communities where the Covered Health Service is rendered.
- Charges that do not exceed the fees that the provider would charge any other party for the same health service.

For Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as otherwise arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated [or authorized by state law].

For Non-Network Benefits, Eligible Expenses are based on either of the following:

Include the provisions that apply for determining Eligible Expenses for Non-Network Benefits.

- When Covered Health Services are received from a non-Network provider within the *United States*, Eligible Expenses are determined, [at our discretion,] based on [the lesser of]:

[1]When using PHCS to determine Eligible Expenses for Non-Network Benefits, include the following and delete MNRP provisions.

  - [[1]For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
  - When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on [___]% of the amount that the *Centers for Medicare and Medicaid Services (CMS)* would have paid under the Medicare program for the drug determined by either of the following:
    - Reference to available CMS schedules.
    - Methods similar to those used by CMS.
  - Fee(s) that are negotiated with the provider.
  - [50 - 100]% of the billed charge.
  - A fee schedule that we develop.]

[2]When using MNRP to determine Eligible Expenses for Non-Network Benefits, include the following and delete PHCS provisions.

  - [[2]Fee(s) that are negotiated with the provider.
  - [____]% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service [within the geographic market].
  - [50 - 100]% of the billed charge.
  - A fee schedule that we develop.]

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.

Provider Network

We or our affiliates arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of

care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Continuity of Care

Continuity of care is provided under the Policy. In order for health services to be covered as Network Benefits, you must notify the company immediately if either of the following situations applies to you:

- Newly Eligible Persons who are being treated by a Non-Network provider for a current episode of an acute condition may continue to receive treatment from the Non-Network provider until the earlier of (1) the end of the current episode of treatment or (2) 90 days.
- Covered Persons who are being treated for a current episode of an acute condition by a Network provider when the provider's contract terminates may continue to receive treatment from that provider until the earlier of (1) the end of the current episode of treatment or (2) 90 days.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses at our discretion.

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Policy.

Health Services from Non-Network Providers Paid as Network Benefits

For Covered Health Services provided within the *United States*, if specific Covered Health Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

NOTE: Product name of "Global Choice" filed as variable to allow name change in future.

[Global Choice]

[United HealthCare Insurance Company

[Non-Differential PPO]

Schedule of Benefits

[1]Include when Global Choice Benefits are available for Expatriates.

[2]Include when Global Choice Benefits are available for Inpatriates.

[3]Include when Global Choice Benefits are available for both Expatriates and Inpatriates.

[4]Include when International Benefits are available to Enrolled Dependents.

[[Global Choice] provides Benefits for Covered Health Services that are provided outside the *United States* to Subscribers who are *[[1]Expatriates]* [[3]or] *[[2]Inpatriates]* [[4]and to their Enrolled Dependents].] Benefits are available for Covered Health Services provided by or under the direction of a Physician both outside the *United States* and within the *United States*. The *Certificate of Coverage* (*Certificate*) describes Covered Health Services provided within the *United States*. The *[Global Choice] Rider* describes Covered Health Services provided outside the *United States*.

Include when Global Choice Benefits are available for Expatriates.

[1]Include if we or the group establish residency criteria for eligibility; include "s" if more than one day.

[An *Expatriate* is an Eligible Person who is resident outside the United States. If you cease to be resident outside the *United States,* you must notify the Enrolling Group and us immediately. [[1]You are considered to be resident outside the *United States* if you intend to make that locality your home for a period of [one - ten] [11 - 365] day[s] or longer.]]

Include when Global Choice benefits are available for Inpatriates.

[An *Inpatriate* is an Eligible Person who is a foreign national resident within the *United States*.]

Accessing Benefits

International Benefits apply to Covered Health Services that are provided by or under the direction of a Physician outside the *United States*.

U.S. Benefits apply to Covered Health Services that are provided by or under the direction of a Physician or other provider within the *United States* regardless of their Network status. This Benefit plan does not provide a Network Benefit level or a Non-Network Benefit level for *U.S. Benefits*.

Within the *United States*, we arrange for health care providers to participate in a Network. Depending on the geographic area, you may have access to Network providers. These providers have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from a Network provider, your Coinsurance level will remain the same. However, the portion that you owe may be less than if you received services from a non-Network provider because the Eligible Expense may be a lesser amount.

[1]Always include unless the Shared Savings Program does not apply to Benefits under this COC. "Shared Savings Program" is bracketed to accommodate possible name change.

Depending on the geographic area and the service you receive, you may have access [[1]through our [Shared Savings Program]] to non-Network providers who have agreed to discount their charges for

Covered Health Services. If you receive Covered Health Services from these providers, the Coinsurance will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less [[1]when you receive Covered Health Services from [Shared Savings Program] providers than from other non-Network providers] because the Eligible Expense may be a lesser amount.

You should show your identification card (ID card) every time you request health care services so that the provider knows that you are enrolled under a [UnitedHealthcare] Policy.

If there is a conflict between this *Schedule of Benefits* and any summaries provided to you by the Enrolling Group, this *Schedule of Benefits* will control.

Additional information about the network of providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits*.

Pre-service Benefit Confirmation

We require notification before you receive certain Covered Health Services. Services for which you must provide pre-service notification are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

To notify us, call the telephone number for *Customer Care* on your ID card.

Covered Health Services which require pre-service notification:

- Ambulance - non-emergent air and ground.

Include when group purchases benefits for clinical trials.

- [Clinical trials.]

Include when group purchases benefits for accident-related dental services and notification is required.

- [Dental services - accidental.]
- Dental services - anesthesia and hospitalization.

Include when group does not purchase benefits for durable medical equipment.[1] Include if notification applies only to insulin pumps that exceed a specific dollar amount and insert appropriate dollar amount.

- [Diabetes equipment - insulin pumps [[1]over $[1,000 - 5,000]].]

Include when group purchases benefits for DME. [1]Include if notification applies only to DME that exceeds a specific dollar amount and insert appropriate dollar amount

- [Durable Medical Equipment [[1]over $[1,000 - 5,000]].]

Include when notification is required for home health care.

- [Home health care.]

Include when notification is required for hospice care.

- [Hospice care - inpatient.]

[1]Include when full maternity benefits are sold. [2]Include when complications of pregnancy benefits are sold.

- Hospital inpatient care - all scheduled admissions [[1]and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery] [[2]and stays for Complications of Pregnancy exceeding 96 hours for a cesarean section delivery].

Include when group purchases benefits for infertility services.

- [Infertility services.]

- In vitro fertilization services.

Include when notification is required for Lab/X-ray.

- [Lab, X-ray and diagnostics - sleep studies.]

Include when notification is required for Lab/X-ray-Major Diagnostics.

- [Lab, X-ray and major diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine.]

Include when group purchases benefits for musculoskeletal disorders.

- [Musculoskeletal disorders of the face, neck or head.]

Include when group purchases benefits for obesity surgery.

- [Obesity surgery.]

Include when notification is required for Pharmaceutical Products.

- [Pharmaceutical Products - IV infusions only.]

Include when group purchases benefits for prosthetics and notification is required. [1]Include if notification applies only to prosthetics that exceed a specific dollar amount and insert appropriate dollar amount

- [Prosthetic devices [[1]over $[1,000 - 5,000]].]

[1]Include when group purchases benefits for breast reduction surgery.

- Reconstructive procedures [[1], including breast reduction surgery].

Include when group purchases benefits for rehabilitation services and when notification is required for any service. [1]Include when Chiropractic Treatment is included in the rehabilitation services benefit.

- [Rehabilitation services [[1]and Chiropractic Treatment] - [physical therapy] [,] [and] [occupational therapy] [,] [and] [[1]Chiropractic Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [vision therapy].]

Include when notification is required for scopic procedures.

- [Scopic procedures - outpatient diagnostic and therapeutic.]
- Skilled Nursing Facility and Inpatient Rehabilitation Facility services.

Include when notification is required for outpatient surgeries.

- [Surgery - [all outpatient surgeries] [only for the following outpatient surgeries: [blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators]].]

Include when group purchases benefits for TMJ services.

- [Temporomandibular joint services.]

Include when notification is required for outpatient therapeutics.

- [Therapeutics - [all outpatient therapeutics] [only for the following services: [dialysis] [,] [and] [chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] hyperbaric oxygen therapy].]
- Transplants.

For all other services, we urge you to confirm with us that the services you plan to receive are Covered Health Services. That's because in some instances, certain procedures may not meet the definition of a

Covered Health Service and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By contacting us before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time notice is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

Include when group purchases benefits for mental health/substance abuse services and when prior authorization applies to any MH/SA benefit purchased.

[1]Include if prior authorization is required for International Benefits.

[Mental Health and Substance Abuse Services]

[Mental Health and Substance Abuse Services are not subject to the pre-service notification requirements described above. Instead, for [[1]*International* and] *U.S. Benefits* you must obtain prior authorization from the Mental Health/Substance Abuse Designee before you receive Mental Health Services and Substance Abuse Services. You can contact the Mental Health/Substance Abuse Designee at the telephone number on your ID card.]

Care Coordination[SM]

When we are notified as required, we will work with you to implement the Care Coordination[SM] process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the notification requirements described below do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to notify us before receiving Covered Health Services.

Benefits

Annual Deductibles are calculated on a [calendar] [Policy] year basis.

Out-of-Pocket Maximums are calculated on a [calendar] [Policy] year basis.

Include only when an Annual Maximum Benefit applies.

[The Annual Maximum Benefit is calculated on a [calendar] [Policy] year basis.]

When Benefit limits apply, the limit stated refers to any combination of *International Benefits* and *U.S. Benefits* unless otherwise specifically stated.

Benefit limits are calculated on a [calendar] [Policy] year basis unless otherwise specifically stated.

Payment Term And Description	**Amounts**
Annual Deductible	
[1]Include when an Outpatient Prescription Drug Rider is sold and the Annual Deductible applies to any combination of medical and RX benefits. The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. [[1]The Annual Deductible applies to Covered Health Services	*[1]Include separate International and U.S. headings and statements when Annual Deductible provision applies separately and delete the combined International and U.S. provision below.* ***[[1]International]***

under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Rider*.]

Include when day/visit limits are reduced by the number of days/visit used toward meeting the deductible.

[Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible.]

Include when dollar limits are reduced by the amount used toward meeting the deductible.

[Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a dollar limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the amount used toward meeting the Annual Deductible.]

Include when the carry-over provision applies.

[Any amount you pay for medical expenses in the last three months of the previous year that is applied to the previous Annual Deductible will be carried over and applied to the current Annual Deductible. This carry-over feature applies only to the individual Annual Deductible.]

Include paragraph if the roll-over provision applies to a group in any circumstance.

[When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy.]

Include paragraph if the roll-over provision applies to a group changing from a calendar year to Policy year plan. [1]Include when this applies only to the individual deductible.

[When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for medical expenses in the last three months of the previous calendar year that is applied to the previous Annual Deductible, will be rolled over and applied to the current Policy year Annual Deductible. This roll-over feature applies only to the first Policy year. [[1]This roll-over feature applies only to the individual Annual Deductible.]]

The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Include only when a per occurrence deductible applies.

[The Annual Deductible does not include any applicable Per

Include when separate individual and family deductibles apply (non-embedded).

[For single coverage, the Annual Deductible is $[0 - 15,000] per Covered Person.

If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.]

Include when individual deductible applies (embedded).

[$[0 - 15,000] per Covered Person.]

Include when individual (with family maximum) deductible applies (embedded).

[$[0 - 15,000] per Covered Person, not to exceed $[0 - 45,000] for all Covered Persons in a family.]

Include when there is no annual deductible for International benefits.

[No Annual Deductible.]

[[1]U.S.]

Include when separate individual and family deductibles apply (non-embedded).

[For single coverage, the Annual Deductible is $[0 - 15,000] per Covered Person.

If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.]

Include when individual deductible applies (embedded).

[$[0 - 15,000] per Covered Person.]

Include when individual (with family maximum) deductible applies (embedded).

Occurrence Deductible.]	[$[0 - 15,000] per Covered Person, not to exceed $[0 - 45,000] for all Covered Persons in a family.] *Include when there is no annual deductible for U.S. benefits.* [No Annual Deductible.] *[2]Include the combined International and U.S. heading and statements when Annual Deductible provision applies to combined International and U.S. Benefits and delete the separate International and U.S. provisions above.* ***[[2]International and U.S.]*** *Include when separate individual and family deductibles apply (non-embedded).* [For single coverage, the Annual Deductible is $[0 - 15,000] per Covered Person. If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.] *Include when individual deductible applies (embedded).* [$[0 - 15,000] per Covered Person.] *Include when individual (with family maximum) deductible applies (embedded).* [$[0 - 15,000] per Covered Person, not to exceed $[0 - 45,000] for all Covered Persons in a family.]
Include only when a per occurrence deductible applies. **[Per Occurrence Deductible]**	
[The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible.	***[International]*** *Include when a per occurrence deductible applies to inpatient hospital benefits.* [Hospital - Inpatient Stay: [$100 - 1,000] per day.] [Hospital - Inpatient Stay: [$100 - 2,000]

• The Eligible Expense.]	per Inpatient Stay.] *Include when a per occurrence deductible applies to outpatient surgery benefits.* [Surgery - Outpatient: [$10 - 1,000] per date of service.] *Include when a per occurrence deductible applies to inpatient transplant benefits.* [Transplant - Inpatient Stay: [$100 - 1,000] per day.] [Transplant - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] ***[U.S.]*** *Include when a per occurrence deductible applies to inpatient hospital benefits.* [Hospital - Inpatient Stay: [$100 - 1,000] per day.] [Hospital - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] *Include when a per occurrence deductible applies to outpatient surgery benefits.* [Surgery - Outpatient: [$10 - 1,000] per date of service.] *Include when a per occurrence deductible applies to inpatient transplant benefits.* [Transplant - Inpatient Stay: [$100 - 1,000] per day.] [Transplant - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.]
Out-of-Pocket Maximum	

[1]Include when OOPM includes the Annual Deductible.

[2]Include when OOPM includes the Per Occurrence Deductible.

[3]Include when OOPM includes Copayments.

[4]Include when an Outpatient Prescription Drug Rider is sold and the OOPM applies to any combination of medical and RX benefits.

The maximum you pay per year for [[1]the Annual Deductible,] [[2]the Per Occurrence Deductible,] [[3]Copayments] [[1-2-3]or] Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. [[4]The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Rider*.]

[5]Include only when the plan design does not apply all copayments and coinsurance to the OOPM.

[[5]Copayments and Coinsurance for some Covered Health Services will never apply to the Out-of-Pocket Maximum and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.] Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following:

- Any charges for non-Covered Health Services.

Include bullet if notification requirements apply to any benefit category in the Schedule of Benefits table and if the plan design supports not applying penalties to the OOPM.

- [The amount Benefits are reduced if you do not notify us as required.]
- Charges that exceed Eligible Expenses.
- Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.

Include bullet when an Outpatient Prescription Drug Rider is sold and copayments/coinsurance do not apply to the overall OOPM.

- [Copayments or Coinsurance for Covered Health Services provided under the *Outpatient Prescription Drug Rider*.]

[1]Include separate International and U.S. headings and statements when OOPM provision applies separately, and delete the combined International and U.S. provision below.

[[1]International]

Include when separate individual and family maximums apply (non-embedded).

[For single coverage, the Out-of-Pocket Maximum is $[0 - 45,000] per Covered Person.

If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $[0 - 135,000].]

Include when individual OOPM applies (embedded).

[$[0 - 45,000] per Covered Person.]

Include when individual (with family maximum) applies (embedded).

[$[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.]

Include when the OOPM includes the Annual Deductible.

[The Out-of-Pocket Maximum includes the Annual Deductible.]

Include when the OOPM does not include the Annual Deductible.

[The Out-of-Pocket Maximum does not include the Annual Deductible.]

Include when the OOPM includes the Per Occurrence Deductible.

[The Out-of-Pocket Maximum includes the Per Occurrence Deductible.]

Include when the OOPM does not include the Per Occurrence Deductible.

[The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.]

Include when there is no OOPM.

[No Out-of-Pocket Maximum.]

	[[1]U.S.]
	Include when separate individual and family maximums apply (non-embedded).
	[For single coverage, the Out-of-Pocket Maximum is $[0 - 45,000] per Covered Person.
	If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $[0 - 135,000].]
	Include when individual OOPM applies (embedded).
	[$[0 - 45,000] per Covered Person.]
	Include when individual (with family maximum) applies (embedded).
	[$[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.]
	Include when the OOPM includes the Annual Deductible.
	[The Out-of-Pocket Maximum includes the Annual Deductible.]
	Include when the OOPM does not include the Annual Deductible.
	[The Out-of-Pocket Maximum does not include the Annual Deductible.]
	Include when the OOPM includes the Per Occurrence Deductible.
	[The Out-of-Pocket Maximum includes the Per Occurrence Deductible.]
	Include when the OOPM does not include the Per Occurrence Deductible.
	[The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.]
	Include when there is no OOPM.
	[No Out-of-Pocket Maximum.]
	[2]Include combined International and U.S. headings and statements below when OOPM provision applies to combined Benefits and delete the separate International and U.S. provisions above.

	[[2]International and U.S.] *Include when separate individual and family maximums apply (non-embedded).* [For single coverage, the Out-of-Pocket Maximum is $[0 - 45,000] per Covered Person. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $[0 - 135,000].] *Include when individual OOPM applies (embedded).* [$[0 - 45,000] per Covered Person.] *Include when individual (with family maximum) applies (embedded).* [$[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.] *Include when the OOPM includes the Annual Deductible.* [The Out-of-Pocket Maximum includes the Annual Deductible.] *Include when the OOPM does not include the Annual Deductible.* [The Out-of-Pocket Maximum does not include the Annual Deductible.] *Include when the OOPM includes the Per Occurrence Deductible.* [The Out-of-Pocket Maximum includes the Per Occurrence Deductible.] *Include when the OOPM does not include the Per Occurrence Deductible.* [The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.] *Include when there is no OOPM.* [No Out-of-Pocket Maximum.]
Maximum Policy Benefit	

The maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Policy.	*[1]Include when separate International, and U.S. Maximums apply.* ***[[1]International]*** [$[1,000,000 - 10,000,000] per Covered Person.] [No Maximum Policy Benefit.] ***[[1]U.S.]*** [$[1,000,000 - 10,000,000] per Covered Person.] [No Maximum Policy Benefit.] *[2]Include when combined International and U.S. Maximums applies.* ***[[2]International and U.S.]*** [$[1,000,000 - 10,000,000] per Covered Person.]
Include only when an annual maximum benefit applies. **[Annual Maximum Benefit]**	
[The maximum amount we will pay for Benefits during the year.]	*[1]Include when separate International and U.S. Maximums apply* ***[[1]International]*** [$[2,000 - 500,000] per Covered Person.] ***[[1]U.S.]*** [$[2,000 - 500,000] per Covered Person.] *[2]Include when combined International and U.S. Maximums applies.* ***[[2]International and U.S.]*** [$[2,000 - 500,000] per Covered Person.]

Copayment

Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.

Please note that for Covered Health Services, you are responsible for paying the lesser of:

- The applicable Copayment.
- The Eligible Expense.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Coinsurance
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Benefit Limits

Include when benefit plan design has no additional limits.

[This Benefit plan does not have Benefit limits in addition to those stated below within the Covered Health Service categories in the *Schedule of Benefits* table.]

Include when benefit plan design has limits for either orthopedic or spine surgery.

[In addition to the limits stated below within the Covered Health Service categories in the *Schedule of Benefits* table, the following limits apply:]

Include when orthopedic surgery is limited.

[1]Include when orthopedic surgery is limited to a dollar amount per surgery.

[2]Include when orthopedic surgery is limited to a specific number of surgeries per lifetime.

[3]Include when orthopedic surgery is limited to both a dollar amount per surgery and a specific number of surgeries per lifetime.

- [Benefits for Covered Health Services for orthopedic surgery for joint replacement are limited to [[1]a maximum of $[5,000 - 50,000] per surgery] [[2][1 - 4] orthopedic [surgery] [surgeries] during the entire period of time a Covered Person is enrolled under the Policy] [[3]a maximum of $[5,000 - 50,000] per surgery, not to exceed [1 - 4] orthopedic [surgery] [surgeries] during the entire period of time a Covered Person is enrolled under the Policy].]

Include when spine surgery is limited.

[1]Include when spine surgery is limited to a dollar amount per surgery.

[2]Include when spine surgery is limited to a specific number of surgeries per lifetime.

[3]Include when spine surgery is limited to both a dollar amount per surgery and a specific number of surgeries per lifetime.

- [Benefits for non-emergent spine surgery, including all related services and devices, are limited to [[1]a maximum of $[5,000 - 75,000] per surgery] [[2][1 - 4] spine [surgery] [surgeries] during the entire period of time a Covered Person is enrolled under the Policy] [[3]a maximum of $[5,000 - 75,000] per surgery, not to exceed [1 - 4] spine [surgery] [surgeries] during the entire period of time a Covered Person is enrolled under the Policy].

  This limit does not apply to:

  - Non-emergent surgeries for scoliosis or congenital defects.
  - Emergent surgeries for traumatic spine/spinal cord injury, spinal cord tumor, cauda equine syndrome, infection or neurological motor deficit.]

Include when benefits for spine surgery are provided only after conservative treatment is received.

- [Benefits for non-emergent spine surgery are available only after a Covered Person receives a minimum of a six-week course of conservative, non-surgical treatment provided under the supervision of a Physician. Benefits for spine surgery related to traumatic spine/spinal cord Injury, spinal cord tumor, cauda equine syndrome, infection, neurological motor deficit, scoliosis and congenital defects are not subject to this prior conservative, non-surgical treatment requirement.]

Note: Throughout schedule, variables are provided to require notification for International Benefits. Prior to implementation, the Project Team will determine which categories require notification for International Benefits.

When Benefit limits apply, the limit refers to any combination of International Benefits and U.S. Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Include for groups that purchase benefits for acupuncture services. **1. [Acupuncture Services]**			
Include the limit selected by the group. [Limited to [10 - 100] visits per year.] [Limited to [10 - 100] visits per year, not to exceed $[100 - 5,000] in Eligible Expenses per year.] [Limited to $[100 - $5,000] in Eligible Expenses per year.]	***[International]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[U.S.] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
[2.] Ambulance Services			
Pre-service Notification Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must notify us as soon as possible prior to transport. If you fail to notify us as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance *Include the limit selected by the group.* [Ground ambulance limited to $[500 - 5,000] per year.] *Include the limit selected by the group.* [Air ambulance limited to $[1,000 - 10,000] per year.]	***International*** *Ground Ambulance:* [50 - 100]% *Air Ambulance:* [50 - 100]%	[Yes] [No]	[Yes] [No]
	U.S. *Ground Ambulance:* [50 - 100]% *Air Ambulance:* [50 - 100]%	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
Non-Emergency Ambulance	***International***		

When Benefit limits apply, the limit refers to any combination of International Benefits and U.S. Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Ground or air ambulance, as we determine appropriate.	*Ground Ambulance:* [50 - 100]% *Air Ambulance:* [50 - 100]% ***U.S.*** *Ground Ambulance:* [50 - 100]% *Air Ambulance:* [50 - 100]%	[Yes] [No] [Yes] [No] [Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes] [No] [Yes] [No]
Include for groups that purchase benefits for clinical trials. **[3.] [Clinical Trials]**			
[Pre-service Notification Requirement] [You must notify us as soon as the possibility of participation in a clinical trial arises. If you don't notify us, you will be responsible for paying all charges and no Benefits will be paid.]			
[Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits*.]	***[International]*** [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.] ***[U.S.]*** [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]		
Include for groups that purchase benefits for accident-related dental services. **[4.] [Dental Services - Accident Only]**			
Include when preservice notification is required. *[1]Include applicable reduction in Benefits or no Benefits.* **[Pre-service Notification Requirement]** [For [*International* and] *U.S. Benefits* you must notify us five business days before follow-up (post-Emergency) treatment begins. (You do not have to notify us before the initial Emergency treatment.) If you fail to notify us as required, [[1]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [[1]you will be			

When Benefit limits apply, the limit refers to any combination of International Benefits and U.S. Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
responsible for paying all charges and no Benefits will be paid].]			
Include the limit selected by the group. *[1]Include when per tooth limits apply.* [Limited to $[2,000 - 5,000] per year.] [[1]Benefits are further limited to a maximum of $[500 - 1,500] per tooth.]	***[International]*** [[50 - 100]%] ***[U.S.]*** [[50 - 100]%]	 [Yes] [No] [Yes] [No]	 [Yes] [No] [Yes] [No]
[5.] Diabetes Services			
[1]Include when the durable medical equipment benefit is sold. *[2]Include when the durable medical equipment benefit is not sold.* *[3]Include when notification applies only to equipment that exceeds a minimum dollar amount and insert applicable dollar amount.* *[4]Include applicable reduction in Benefits or no Benefits.*			
Pre-service Notification Requirement For [*International* and] *U.S. Benefits* you must notify us before obtaining any [[1]Durable Medical Equipment] [[2]diabetes equipment] for the management and treatment of diabetes [[3]that exceeds $[1,000 - 5,000] in cost (either purchase price or cumulative rental of a single item)]. If you fail to notify us as required, [[4]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [[4]you will be responsible for paying all charges and no Benefits will be paid].			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	***International*** Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. ***U.S.*** Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items *Include when benefits for durable medical equipment are sold and when state law permits limits on diabetes*	***International*** *[1]Include when both benefits for durable medical equipment and the outpatient prescription drug rider are sold.* [[1]Depending upon where the Covered Health Service is		

When Benefit limits apply, the limit refers to any combination of International Benefits and U.S. Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
equipment. [Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under *Durable Medical Equipment*.] *Include only when benefits for durable medical equipment are sold and when state law does not permit limits on diabetes equipment.* [Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are not subject to the limit stated under *Durable Medical Equipment*.] *Include only when benefits for durable medical equipment are not sold and when benefits for insulin pumps are limited.* [Benefits for insulin pumps are limited to $[500 - 100,000] in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) every [year] [[two-five] years].]	provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Rider*.] *[2]Include when benefits for durable medical equipment are sold, but the outpatient prescription drug rider is not sold.* *[3]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[4]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[2]For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment*. For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [[3]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[4]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] *[5]Include when benefits for durable medical equipment are not sold and the outpatient prescription drug rider is sold.* *[6]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[7]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[5]For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [[6]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[7]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.] Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.] *[8]Include when neither benefits for durable medical equipment nor the outpatient prescription drug rider is sold.* *[9]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[10]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[8]For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [[9]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[10]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] ***U.S.*** *[1]Include when both benefits for durable medical equipment and*		

When Benefit limits apply, the limit refers to any combination of International Benefits and U.S. Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	the outpatient prescription drug rider are sold. [[1]Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Rider*.] *[2]Include when benefits for durable medical equipment are sold, but the outpatient prescription drug rider is not sold.* *[3]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[4]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[2]For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment*. For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [[3]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[4]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] *[5]Include when benefits for durable medical equipment are not sold and the outpatient prescription drug rider is sold.* *[6]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[7]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[5]For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [[6]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[7]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.] Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.] *[8]Include when neither benefits for durable medical equipment nor the outpatient prescription drug rider is sold.* *[9]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[10]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[8]For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [[9]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[10]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		

When Benefit limits apply, the limit refers to any combination of International Benefits and U.S. Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Include for groups that purchase benefits for DME. **[6.] [Durable Medical Equipment]**			
[1]*Include when notification applies only to DME that exceeds a minimum dollar amount and insert applicable dollar amount.* [2]*Include applicable reduction in Benefits or no Benefits.* **[Pre-service Notification Requirement]** [For [*International* and] *U.S. Benefits* you must notify us before obtaining any Durable Medical Equipment [[1]that exceeds $[1,000 - 5,000] in cost (either purchase price or cumulative rental of a single item)]. If you fail to notify us as required, [[2]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [[2]you will be responsible for paying all charges and no Benefits will be paid].]			
Include the limit selected by the group. [1]*Include either option as standard plan design.* [[1]Limited to $[500 - 100,000] in Eligible Expenses per year. Benefits are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two-five] years].] [[1]Limited per year as follows: • [$[500 - 10,000] in Eligible Expenses for Tier 1.Tier 1 includes disposable supplies necessary for the effective use of covered Durable Medical Equipment.] • [$[10,001 - 25,000] in Eligible Expenses for Tier 2.] • [$[25,001 - 100,000] in Eligible Expenses for Tier 3.] These Tier limits include repair. Benefits for replacement are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two-five] years].]	***[International]*** [[50 - 100]%] ***[U.S.]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]

When Benefit limits apply, the limit refers to any combination of International Benefits and U.S. Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[7.] Emergency Health Services - Outpatient			
Include when benefit is limited. [Limited to $[100 - 5,000] per year.]	***International*** [50 - 100]% ***U.S.*** [50 - 100]%	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
Include for groups that purchase hearing aid benefits. **[8.] [Hearing Aids]**			
Include the limit selected by the group. [Limited to $[500 - 5,000] per year.] [Limited to $[500 - 5,000] for each hearing impaired ear every [24 - 36] months.] [Limited to $[500 - 25,000] per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy.]	***[International]*** [[50 - 100]%] ***[U.S.]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[9.] Home Health Care			
Include if pre-service notification is required. [1]*Include applicable reduction in Benefits.* **[Pre-service Notification Requirement]** [For [*International* and] *U.S. Benefits* you must notify us five business days before receiving services or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.]			
Include the limit selected by the group. [Limited to [40 - 200] visits per year. One visit equals up to four hours of skilled care services.] [Limited to $[500 - 5,000] per year.] [Limited to [40 - 200] visits per year to a maximum of $[500 - 5,000] in Eligible	***International*** [50 - 100]%	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of International Benefits and U.S. Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Expenses per year.] *Include when infusion administration only is not included in the limit.* [This visit limit does not include any service which is billed only for the administration of intravenous infusion.]	***U.S.*** [50 - 100]%	[Yes] [No]	[Yes] [No]
[10.] Hospice Care			
Include if pre-service notification is required. [1]*Include applicable reduction in Benefits.* **[Pre-service Notification Requirement]** [For [*International* and] *U.S. Benefits* you must notify us five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.] *Include if pre-admission notification is required.* [In addition, for *U.S. Benefits*, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.]			
	International [50 - 100]% ***U.S.*** [50 - 100]%	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[11.] Hospital - Inpatient Stay			
[1]*Include applicable Benefit level.* **Pre-service Notification Requirement** For [*International* and] *U.S. Benefits* for a scheduled admission, you must notify us five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses. *Include if pre-admission notification is required.* [In addition, for *U.S. Benefits* you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]			
	International		

When Benefit limits apply, the limit refers to any combination of International Benefits and U.S. Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[50 - 100]% ***U.S.*** [50 - 100]%	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied] [Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]
Include for groups that purchase infertility benefits. **[[12]. Infertility Services]**			
When this benefit is purchased, pre-service notification will always be required. [1]Include applicable reduction in Benefits or no Benefits. **[Pre-service Notification Requirement]** [You must notify us as soon as the possibility of the need for Infertility Services arises. If you fail to notify us as required, [[1]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [[1]you will be responsible for paying all charges and no Benefits will be paid].]			
Include the limit selected by the group. *[1]Include when the maximum benefit is combined with infertility drugs under the RX rider.* [Limited to $[2,000 - 30,000] per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. [[1]This limit includes Benefits for infertility medications provided under the *Outpatient Prescription Drug Rider*.]]	***[International]*** [[50 - 100]%] ***[U.S.]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[13.] Lab, X-Ray and Diagnostics - Outpatient			
Include when pre-service notification is required for sleep studies. *[1]Include applicable reduction in Benefits.*			

When Benefit limits apply, the limit refers to any combination of International Benefits and U.S. Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[Pre-service Notification Requirement] [For [*International* and] *U.S. Benefits* for sleep studies, you must notify us five business days before scheduled services are received. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.]			
Include limit selected by group. [Limited to $[100 - 5,000] per year.]	***International*** [50 - 100]% ***U.S.*** [50 - 100]%	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[14.] Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
Include when pre-service notification is required for CT, PET, MRI, MRA and nuclear medicine. *[1]Include applicable reduction in Benefits.* **[Pre-service Notification Requirement]** [For [*International* and] *U.S. Benefits* you must notify us five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.]			
Include limit selected by group. [Limited to $[100 - 5,000] per year.]	***International*** [50 - 100]% ***U.S.*** [50 - 100]%	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
Include for groups that purchase inpatient and intermediate mental health/substance abuse benefits. This is a mandated offer in Arkansas. If the employer chooses not to have this benefit, they must refuse this benefit in writing. Remove entire benefit if group purchases MH full parity. **[[15.] Mental Health and Substance Abuse Services - Inpatient and Intermediate]**			
When this benefit is purchased, prior authorization will always be required. **[Prior Authorization Requirement]** [For [*International* and] *U.S. Benefits* you must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be			

When Benefit limits apply, the limit refers to any combination of International Benefits and U.S. Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
responsible for paying all charges and no Benefits will be paid.]			
Include the limit selected by the group. [Limited to [10 - 100] days per year.] [Mental Health Services are limited to [10 - 100] days per year.] [Substance Abuse Services are limited to [10 - 100] days per year.]	***[International]*** [[50 - 100]%] ***[U.S.]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
Include for groups that purchase outpatient mental health/substance abuse benefits. This is a mandated offer in Arkansas. If the employer chooses not to have this benefit, they must refuse this benefit in writing. Remove entire benefit if group purchases MH full parity. **[[16.] Mental Health and Substance Abuse Services - Outpatient]**			
Include authorization language only for groups that elect the "Employer Coverage" option. Delete authorization language for groups that elect the "National Service Center" option. **[Prior Authorization Requirement]** [For [*International* and] *U.S. Benefits* you must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.]			
Include the limit selected by the group. [Limited to [10 - 100] visits per year.] [Mental Health Services are limited to [10 - 100] visits per year.] [Substance Abuse Services are limited to [10 - 100] visits per year.]	***[International]*** [[50 - 100]%] ***[U.S.]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
Include for groups that purchase benefits for obesity surgery. **[[17.] Obesity Surgery]**			

When Benefit limits apply, the limit refers to any combination of International Benefits and U.S. Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
When this benefit is purchased, pre-service notification will always be required. [1]*Include applicable Benefit level.* **[Pre-service Notification Requirement]** [You must notify us [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.] *Include if pre-admission notification is required.* [In addition, for [*International* and] *U.S. Benefits* you must contact us 24 hours before admission for an Inpatient Stay.] **[It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.]**			
[1]*Insert the limit selected by the group.* [Limited to $[[1]50,000 - 250,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy.]	***[International]*** [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.] ***[U.S.]*** [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]		
Include if group purchases benefits for ostomy supplies. **[[18.] Ostomy Supplies]**			
Include the limit selected by the group. [Limited to $[500 - 25,000] per year.]	***[International]*** [[50 - 100]%] ***[U.S.]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[19.] Pharmaceutical Products - Outpatient			
Include when notification is required for IV infusions. [1]*Include applicable reduction in Benefits.* **[Pre-service Notification Requirement]** [For [*International* and] U.S. Benefits you must notify us five business days before scheduled intravenous infusions are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible			

When Benefit limits apply, the limit refers to any combination of International Benefits and U.S. Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Expenses.]		
Include limit selected by group. [Limited to $[100 - 5,000] per year.]	***International*** [[50 - 100]%] *Include when coinsurance is tiered and select the appropriate number of tiers by plan design.* [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6] ***U.S.*** [[50 - 100]%] *Include when coinsurance is tiered and select the appropriate number of tiers by plan design.* [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[20.] Physician Fees for Surgical and Medical Services			
	International [50 - 100]% ***U.S.***	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of International Benefits and U.S. Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[50 - 100]%	[Yes] [No]	[Yes] [No]
[21.] Physician's Office Services - Sickness and Injury			
Include if group chooses to limit benefit. [1]Insert limit selected by group [Limited to [[1]2 - 10] visits per year.]	***International*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 100] per visit for a Specialist Physician office visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 100] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] ***U.S.***	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of International Benefits and U.S. Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 100] per visit for a Specialist Physician office visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 100] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year]	[Yes] [No]	[Yes] [No]
[22.] Pregnancy - Maternity Services			
Pre-service Notification Requirement			
[1]*Include applicable reduction in Benefits.*			
For [*International* and] *U.S. Benefits* you must notify us as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a			

When Benefit limits apply, the limit refers to any combination of International Benefits and U.S. Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
cesarean section delivery. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses. **It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.**			
	International *[1]Include when an annual deductible applies to International benefits.* *[2]Include when International services in the Physician's office are subject to a Copayment.* Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* [[1]except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay]. [[2]For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.] ***U.S.*** *[1]Include when an annual deductible applies to U.S. benefits.* *[2]Include when U.S. services in the Physician's office are subject to a Copayment.* Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* [[1]except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay]. [[2]For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.]		
[23.] Preventive Care Services			
Include when preventive care is limited and select the limit that applies. [Preventive care services are limited to $[100 - 1,000] per year.] **Physician office services** [Limited to [2 - 10] visits per year.] Well baby and well child care includes, but not limited to, 20 visits at approximately the following age intervals: birth, two weeks, two months,	***International*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 -	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of International Benefits and U.S. Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
four months, six months, nine months, 12 months, 15 months, 18 months, two years, three years, four years, five years, six years, eight years, 10 years, 12 years, 14 years, 16 years, and 18 years. No Copayment, Coinsurance or Deductible will be applicable to Network or Non-Network children's immunizations.	100] per visit for a Specialist Physician office visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]		
	U.S.		
	[[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 100] per visit for a Specialist Physician office visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]	[Yes] [No]	[Yes] [No]
Lab, X-ray or other preventive tests:	***International***		

When Benefit limits apply, the limit refers to any combination of International Benefits and U.S. Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service] ***U.S.*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
Include when group purchases benefits for prosthetic devices. **[24.] [Prosthetic Devices]**			
Include if notification is required. *[1]Include when notification applies only to prosthetics that exceed a minimum dollar amount and insert applicable dollar amount.* *[2]Include applicable reduction in Benefits or no Benefits.* **[Pre-service Notification Requirement]** [For [*International* and] *U.S. Benefits* you must notify us before obtaining prosthetic devices [[1]that exceed $[1,000 - 5,000] in cost per device]. If you fail to notify us as required, [[2]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [[2]you will be responsible for paying all charges and no Benefits will be paid].]			
Include the limit selected by the group. *[1]Include either option as standard.* [[1]Limited to $[2,500 - 100,000] per year. Benefits are limited to a single purchase of each type of prosthetic device every [year] [[two-five] years].] [[1]Limited per year as follows: • A maximum of $[10,000 - 30,000] per body part for each arm, leg, hand or foot. • A maximum of $[5,000 - 15,000] per body part for each eye, ear, nose, face, breast, speech aid prosthetics or tracheo-esophageal voice prosthetics. These limits include repair. Benefits for replacement are limited to a single	***[International]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of International Benefits and U.S. Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
purchase of each type of prosthetic device every [year] [[two-five] years]. *Always include statement below except when prosthetics are not limited.* [Once this limit is reached, Benefits continue to be available for items required by the Women's Health and Cancer Rights Act of 1998.]	***[U.S.]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
[25.] Reconstructive Procedures			

[1]*Include applicable Benefit level.*

Pre-service Notification Requirement

For [*International* and] *U.S. Benefits* you must notify us five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.

Include if pre-admission notification is required.

[In addition, for [*International* and] *U.S. Benefits* you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).]

International

Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.

Include when group does not purchase benefits for prosthetic devices.

[1]*Include when sold with a plan that has an annual deductible and select either "are" or "are not."*

[2]*Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."*

[For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [[1]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[2]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]

U.S.

Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered

When Benefit limits apply, the limit refers to any combination of International Benefits and U.S. Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Health Service category in this *Schedule of Benefits*. *Include when group does not purchase benefits for prosthetic devices.* *[1]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[2]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [[1]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[2]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
Include entire section when rehabilitation services benefit is sold. *[1]Include when Chiropractic Treatment benefits are sold.* **[[26.] Rehabilitation Services - Outpatient Therapy [[1]and Chiropractic Treatment]]**			
Include when notification is required for any rehabilitation service. *[1]Include applicable Benefit level.* **[Pre-service Notification Requirement]** [For [*International* and] *U.S. Benefits* you must notify us five business days before receiving [physical therapy] [,] [and] [occupational therapy] [,] [and] [Chiropractic Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [vision therapy] or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.]			
Include when per therapy limits apply. *[1]Include when Chiropractic Treatment benefits are sold. Select either visit or dollar limits as applicable.* *[2]Include when vision therapy benefits are sold.* [Limited per year as follows: • [10-100] visits of physical therapy. • [10-100] visits of occupational	***[International]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of International Benefits and U.S. Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
therapy. • [[1][10-100] visits of Chiropractic Treatment.] • [[1]$[300 - 1,000] of Chiropractic Treatment.] • [10-100] visits of speech therapy. • [10-100] visits of pulmonary rehabilitation therapy. • [10-100] visits of cardiac rehabilitation therapy. • [10-100] visits of post-cochlear implant aural therapy. • [[2][10-100] visits of vision therapy.]]			
Include when combined therapy visit limits apply. [Any combination of outpatient rehabilitation services is limited to [10 - 160] visits per year.]	***[U.S.]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
Include when combined therapy dollar limits apply. [Any combination of outpatient rehabilitation services is limited to $[750 - 12,000] per year.]			
Include when combined therapy visit limits apply separately to International Benefits and to U.S. Benefits. [*International Benefits* for any combination of outpatient rehabilitation services are limited to [10 - 160] visits per year. *U.S. Benefits* for any combination of outpatient rehabilitation services are limited to [10 - 160] visits per year.]			
[27.] Scopic Procedures - Outpatient Diagnostic and Therapeutic			
Include when notification is required for scopic procedures.			

When Benefit limits apply, the limit refers to any combination of International Benefits and U.S. Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[1]*Include applicable Benefit level.* **[Pre-service Notification Requirement]** [For [*International* and] *U.S. Benefits* you must notify us five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.]			
	International [50 - 100]% ***U.S.*** [50 - 100]%	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[28.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
[1]*Include applicable Benefit level.* **Pre-service Notification Requirement** For [*International* and] *U.S. Benefits* for a scheduled admission, you must notify us five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses. *Include if pre-admission notification is required.* [In addition, for *U.S. Benefits* you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]			
Include limit selected by group. [Limited to [40 - 180] days per year.] [*International Benefits* are limited to [40 - 180] days per year. *U.S. Benefits* are limited to [40 - 180] days per year.]	***International*** [50 - 100]% ***U.S.*** [50 - 100]%	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[29.] Surgery - Outpatient			
Include when notification is required. [1]*Include applicable Benefit level.* **[Pre-service Notification Requirement]** [For [*International* and] *U.S. Benefits* [for all outpatient surgeries] [for [blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,]			

When Benefit limits apply, the limit refers to any combination of International Benefits and U.S. Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators]] you must notify us five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
	International		
	[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]
	U.S.		
	[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]
Include when group purchases TMJ benefit. **[[30.] Temporomandibular Joint Services]**			
When this benefit is purchased, pre-service notification will always be required. [1]*Include applicable Benefit level.* **[Pre-service Notification Requirement]** [For [*International* and] *U.S. Benefits* you must notify us five business days before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.] *Include if pre-admission notification is required.* [In addition, for [*International* and] *U.S. Benefits* you must contact us 24 hours before admission for scheduled inpatient admissions.]			
Include the limit selected by the group. [Limited to $[1,000 - 20,000] per year.]	***[International]*** [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]		
	[U.S.] [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each		

When Benefit limits apply, the limit refers to any combination of International Benefits and U.S. Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Covered Health Service category in this *Schedule of Benefits*.]		
[31.] Therapeutic Treatments - Outpatient			
Include when notification is required. [1]*Include applicable Benefit level.* **[Pre-service Notification Requirement]** [For [*International* and] *U.S. Benefits* you must notify us [for all outpatient therapeutic services] [for the following outpatient therapeutic services] five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible.] [Services that require notification: [dialysis] [,] [and] chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [hyperbaric oxygen therapy].] If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.]			
	International [50 - 100]% ***U.S.*** [50 - 100]%	 [Yes] [No] [Yes] [No]	 [Yes] [No] [Yes] [No]
[32.] Transplantation Services			
Pre-service Notification Requirement For [*International* and] *U.S. Benefits* you must notify us as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't notify us and if, as a result, the services are not performed at a Designated Facility, [*International* and] *U.S. Benefits* will not be paid. *Include if pre-admission notification is required.* [In addition, for *U.S. Benefits* you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]			
	International [50 - 100]% ***U.S.*** [50 - 100]%	 [Yes] [No] [Yes] [No]	 [Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied] [Yes] [No] [Yes, after the Per Occurrence

When Benefit limits apply, the limit refers to any combination of International Benefits and U.S. Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
			Deductible is satisfied]
[33.] Urgent Care Center Services			
Include when urgent care services are limited and insert the limit selected by the group. [Limited to $[100 - 5,000] per year.] [Limited to [2 - 10] visits per year.]	***International*** [50 - 100]% ***U.S.*** [50 - 100]%	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
Include when group purchases benefits for vision exams. **[[34.] Vision Examinations]**			
[Limited to [1 exam] [[2-3] exams] per year.] [Limited to [1 exam] [[2-3] exams] every [2 - 3] years.]	***[International]*** [[50 - 100]%] ***[U.S.]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
Include when group purchases benefits for wigs. **[[35.] Wigs]**			
Include the limit selected by the group. [Limited to $[100 - 1,000] per year.] [Limited to $[100 - 5,000] every [24 - 36] months.]	***[International]*** [[50 - 100]%] ***[U.S.]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]

Additional Benefits Required By Arkansas Law

[36.] Dental Services - Anesthesia and Hospitalization	

Pre-service Notification Requirement

Any applicable notification requirements will be the same as those stated under Hospital - Inpatient Stay

When Benefit limits apply, the limit refers to any combination of International Benefits and U.S. Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
in this Schedule of Benefits.			
	International [50 - 100%] [*International Benefits* are not available.]	[Yes] [No] [*International Benefits* are not available.]	[Yes] [No] [*International Benefits* are not available.]
	U.S. Benefits will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.		
[37.] In Vitro Fertilization Services			
[1]*Include applicable reduction in Benefits or no Benefits.* **Pre-service Notification Requirement** You must notify us as soon as the possibility of the need for in vitro fertilization arises. If you fail to notify us as required, [[1]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [[1]you will be responsible for paying all charges and no Benefits will be paid].			
Limited to a lifetime maximum of $15,000.	***International*** [50 - 100%] [*International Benefits* are not available.] ***U.S.*** [50 - 100%]	[Yes] [No] [*International Benefits* are not available.] [Yes] [No]	[Yes] [No] [*International Benefits* are not available.] [Yes] [No]
[38.] Medical Foods			
	International [50 - 100%] [*International Benefits* are not available.] [1]*Include when group purchases the Outpatient Prescription Drug Rider.* ***Network*** Depending upon	[Yes] [No] [*International Benefits* are not available.] [Yes] [No]	[Yes] [No] [*International Benefits* are not available.] [Yes] [No]

When Benefit limits apply, the limit refers to any combination of International Benefits and U.S. Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	where the Covered Health Service is provided, Benefits will be [50 - 100]% [[1]or as provided under the *Outpatient Prescription Drug Rider*].		
Include ONLY when group purchases plan with MH full parity. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. **[[39.] Mental Health Services - Inpatient and Intermediate]**			
[Prior Authorization Requirement] [You must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.]			
	International [50 - 100%] [*International Benefits* are not available.]	[Yes] [No] [*International Benefits* are not available.]	[Yes] [No] [*International Benefits* are not available.]
Limited to [10-100] days per year.] [Non-Network Benefits are limited to [10-100] days per year.]	***U.S.*** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Include ONLY when group purchases plan with MH full parity. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. **[[41.] Mental Health Services - Outpatient]**			
When this benefit is purchased, prior authorization will always be required. **[Prior Authorization Requirement]** [You must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will			

When Benefit limits apply, the limit refers to any combination of International Benefits and U.S. Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
be paid.]			
	International		
	[50 - 100%]	[Yes] [No]	[Yes] [No]
	[*International Benefits* are not available.]	[*International Benefits* are not available.]	[*International Benefits* are not available.]
	U.S.		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.**]**		
[41.] Musculoskeletal Disorders of the Face, Neck or Head]			
[Pre-service Notification Requirement] [Depending upon where the Covered Health Service is provided, any applicable notification or authorization requirements will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]			
	International		
	[50 - 100%]	[Yes] [No]	[Yes] [No]
	[*International Benefits* are not available.]	[*International Benefits* are not available.]	[*International Benefits* are not available.]
[Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits*.]	***U.S.*** [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]		
Include ONLY when group purchases plan with inpatient/intermediate SA benefits with MH full parity or no MH. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. **[42.] Substance Abuse Services - Inpatient and Intermediate]**			
When this benefit is purchased, prior authorization will always be required. **[Prior Authorization Requirement]**			

When Benefit limits apply, the limit refers to any combination of International Benefits and U.S. Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[You must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.]			
[Limited to [10-100] days per year.] [Non-Network Benefits are limited to [10-100] days per year.]	***International*** [50 - 100%] [*International Benefits* are not available.] ***U.S.*** [50 - 100%]	[Yes] [No] [*International Benefits* are not available.] [Yes] [No]	[Yes] [No] [*International Benefits* are not available.] [Yes] [No]
[43.] State Mandate			
Notification Language to Appear Here			
[Limited to]	***International*** [50 - 100%] [*International Benefits* are not available.] ***U.S.*** [50 - 100%]	[Yes] [No] [*International Benefits* are not available.] [Yes] [No]	[Yes] [No] [*International Benefits* are not available.] [Yes] [No]
Include ONLY when group purchases plan with inpatient/intermediate SA benefits with MH full parity or no MH. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. **[43.] Substance Abuse Services - Outpatient**			
When this benefit is purchased, prior authorization will always be required. **[Prior Authorization Requirement]** [You must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.]			
	International		

When Benefit limits apply, the limit refers to any combination of International Benefits and U.S. Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[50 - 100%] [*International Benefits* are not available.]	[Yes] [No] [*International Benefits* are not available.]	[Yes] [No] [*International Benefits* are not available.]
[Limited to [10-100] days per year.]	***U.S.***		
[Non-Network Benefits are limited to [10-100] days per year.]	[50 - 100%]	[Yes] [No]	[Yes] [No]

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Covered Health Services from non-Network providers, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Certificate of Coverage*.

When Covered Health Services are received from a provider outside the *United States*, Eligible Expenses are determined, at our discretion, based on:

- Any applicable contracted fee(s) with that provider.
- Charges that are representative of the average and prevailing charge for the same health service in the same or similar geographic communities where the Covered Health Service is rendered.
- Charges that do not exceed the fees that the provider would charge any other party for the same health service.

When Covered Health Services are received from a provider within the *United States*, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, [at our discretion,] based on [the lesser of]:

[1]*When using PHCS to determine Eligible Expenses, include the following and delete MNRP provisions.*

- **[**[1]For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
- When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on [___]% of the amount that the *Centers for Medicare and Medicaid Services (CMS)* would have paid under the Medicare program for the drug determined by either of the following:
  - Reference to available CMS schedules.
  - Methods similar to those used by CMS.
- Fee(s) that are negotiated with the provider.

- [50 - 100]% of the billed charge.
- A fee schedule that we develop.**]**

[2]When using MNRP to determine Eligible Expenses, include the following and delete PHCS provisions.

- **[**[2]Fee(s) that are negotiated with the provider.
- [____]% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service [within the geographic market].
- [50 - 100]% of the billed charge.
- A fee schedule that we develop.**]**

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

Continuity of Care

Continuity of care is provided under the Policy. In order for health services to be covered as Network Benefits, you must notify the company immediately if either of the following situations applies to you:

- Newly Eligible Persons who are being treated by a Non-Network provider for a current episode of an acute condition may continue to receive treatment from the Non-Network provider until the earlier of (1) the end of the current episode of treatment or (2) 90 days.
- Covered Persons who are being treated for a current episode of an acute condition by a Network provider when the provider's contract terminates may continue to receive treatment from that provider until the earlier of (1) the end of the current episode of treatment or (2) 90 days.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses at our discretion.

SERFF Tracking Number:	*UHLC-125976134*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41226*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Arkansas Global Choice*		
Project Name/Number:	*/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UHLC-125976134*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41226*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Arkansas Global Choice*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Review Status:	
Bypassed -Name:	Certification/Notice	Approved-Closed	01/12/2009
Bypass Reason:	Not Applicable		
Comments:			

		Review Status:	
Bypassed -Name:	Application	Approved-Closed	01/12/2009
Bypass Reason:	Not Applicable		
Comments:			

		Review Status:	
Bypassed -Name:	Health - Actuarial Justification	Approved-Closed	01/12/2009
Bypass Reason:	Not Applicable		
Comments:			

		Review Status:	
Bypassed -Name:	Outline of Coverage	Approved-Closed	01/12/2009
Bypass Reason:	Not Applicable		
Comments:			

		Review Status:	
Satisfied -Name:	Cover Letter and Forms Listing	Approved-Closed	01/12/2009

Comments:
Cover letter and forms listing.
Attachments:
Global Choice Cover.pdf
Global Choice Form listing.pdf

December 31, 2008

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

Re: United HealthCare Insurance Company
NAIC No. 79413
Group Health Forms:

GLBCHC.07.AR (Global Choice Rider)

SBN.GLBCHCCP.I.07.AR (Global Choice Schedule of Benefits - Choice Plus)

SBN.GLBCHCND.I.07.AR (Global Choice Schedule of Benefits - Non-Differential PPO)

Dear Ms. Minor:

On behalf of United HealthCare Insurance Company, I am submitting the enclosed group health forms for your Department's review and approval. This is a new rider and two new schedules of benefits that we are filing to be used with our current 2007 Group Policy and Certificate of Coverage series of forms (including all other approved riders and amendments for that series) which was approved by your department on 2/26/2007. Our intent is to use these forms for large employer groups only.

The Global Choice Rider and Schedule of Benefits will be issued to employer groups that elect to provide benefits for expatriate employees who are temporarily working outside the United States and for inpatriate employees who are temporarily working within the United States, but who will occasionally return to their home country. The benefits will provided as an additional "International" level of benefits to the two underlying plans for benefits within the United States. These two plans are based on our Choice Plus and Non-Differential PPO products that were previously approved for this series of forms.

Forms for Which We Seek Approval

The forms for which we seek approval are identified on the attached "Forms Listing." The readability/Flesch score is provided as well.

These materials represent final printed format (with the exception of variable text and corresponding instructions—please see the following paragraphs for explanation). Once approved, these forms will be used to support the issuance of our portfolio of group health products for Global Choice that is offered in your state.

Explanation of Variable Text

Each form is made up of:

- **Nonvariable Text** that always appears in an issued document.
- **Variable Text** that may or may not appear in an issued document depending on the specific product and plan design selected by the Enrolling Group. Variable text is enclosed in brackets. Whenever text is bracketed, we have included text that explains the logic of the

variable; brackets do not appear in the document issued to a member. Variable text will appear unbracketed in the final documents issued to the employer and/or member.

- **Instruction text** provides the logic for when text is included or removed. Please note that instruction text appears only in the filing copy and will not appear in the document issued to a member. Following are two examples of instruction text:

Include when group purchases benefits for obesity surgery.

Include when notification is required for hospice care.

Information contained within these forms may also be used in an online format with appropriate changes in font, format and design to more easily accommodate online viewing or issuance. We want to assure the Department that education will be provided to the brokers, employer groups and the employees regarding access and alternatives to electronic issuance.

If you have any questions or concerns regarding this submission, please feel free to call me at the number shown below.
Sincerely,

Ebony Terry
Compliance Specialist
United HealthCare Insurance Company
4 Taft Court
Rockville, MD 20850

Ph: 301.838.5611
Fax: 301.838.5676
Toll free: 800-250-6180 Ext. 85611
Email: Ebony_N_Terry@msn.com

Global Choice Forms Listing For United HealthCare Insurance Company

Form Number	Description of Forms	Flesch or Readability Score
	Schedules of Benefits	
SBN.GLBCHCCP.I.07.AR	Schedule of Benefits for Choice Plus Global Choice	49.6
SBN.GLBCHCND.I.07.AR	Schedule of Benefits for Non-Differential PPO Global Choice	50.1
	Riders	
GLBCHC.07.AR	Global Choice Rider	45.1